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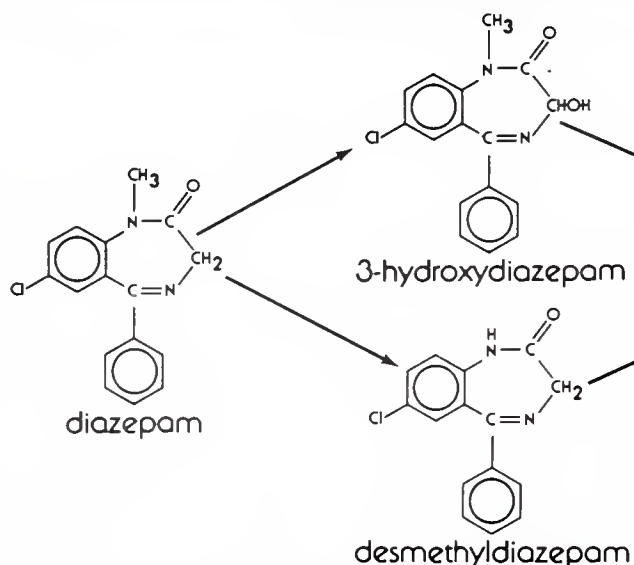
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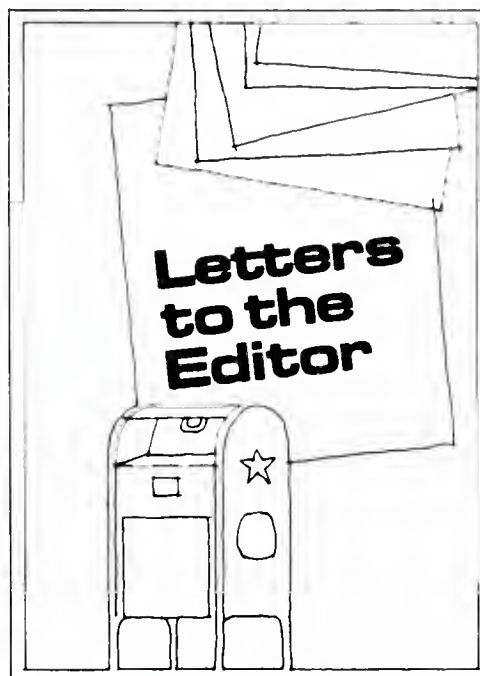
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To The Editor:

I am writing this letter in response to the recent HMA article:

Lehman CW: Sugar Cane Smoke, an Allergenic Agent. HAWAII MEDICAL JOURNAL 35:336-339, 1976 (November).

In this article, on page 338, there are two arithmetic errors in the published calculations of the phi coefficient. [Details are omitted—ED.]

Any reader of the article who was dubious of the results obtained by the author, might be informed that I took the author's data in Table I, assigned a positive or negative history to each case, assigned a positive or negative skin test result to each case (basing positivity for a skin test with sugar cane smoke being at least one dilution weaker than the glycerine response in the same patient), and calculated a phi coefficient. For my calculations: $a=1$, $b=14$, $c=14$, $d=7$ resulted; $\phi = 0.600$ ($N=36$); $X^2 = 12.96$. This more conservative treatment of the data still revealed the X^2 level of significance to be $P<0.01$.

In summary, Dr. Lehman has preliminarily demonstrated that sugar cane smoke can be an allergenic agent in persons previously exposed to this smoke, and has documented the fact that remarkable allergenic response is possible upon skin testing individuals with sugar cane smoke (patient D.S.—positive whealing at 1:3125 dilution; glycerine control negative.)

Dr. Lehman's preliminary work indicates that subsequent studies are definitely in order, including:

- (1) precise chemical identification of the allergenic substances in sugar cane smoke
- (2) comparison of the identified substances (allergenic, in sugar cane smoke) with natural and combusted substances from other plants and materials to identify identical or cross-reacting antigenic sources (N.B., Dr. Lehman had one case, T.W., that had a negative history of exposure but a positive skin test—why: inaccurate history, subclinical exposure, or exposure to similar antigen from a different source?)
- (3) evaluation of a large series of persons by skin testing who never resided in sugar cane areas nor been exposed to these areas nor burning sugar cane—to assess (2) above

continued page 24

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RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



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Adolescent Alcohol Abuse in Hawaii

PHILLIP D.K. LEE* and ROBERT J. LATTA, M.D.**, Honolulu

• *Alcohol has been labelled "the most medically dangerous drug in use today."¹ Alcohol abuse ranks among the top three causes of death in the United States.² It has been widely publicized as a rapidly growing problem among adolescents, affecting an estimated one-half million minors.³ Its significance is related to the role of adolescent drinking in later adult alcoholism. A recent apparent increase may be related to a trend away from other drugs.*

An important factor in the seriousness of adult alcoholism is the age of onset. Studies have shown that the sooner an individual begins the use of alcohol, the more likely he is to experience problems from alcohol usage later in life.⁴ Most adult alcohol users started drinking by their mid-teens.⁵ It has been estimated that 5-10% of those who drink will develop alcoholism.⁶

Among adolescents today, a trend away from drugs such as heroin and LSD and toward the use of alcohol is occurring across the nation,⁷ and is approaching epidemic proportions in many areas.⁸ The reasons for this trend are not entirely clear, but may include the relative social acceptability of alcohol use and the difficulty in obtaining other drugs. In any case, this trend indicates the need for greater preventive measures and an awareness of the dangers of alcohol abuse.

Unfortunately, reliable information concerning juvenile alcohol abuse in Hawaii is not readily available. The considerable anecdotal data suggest a problem in this area; however, few substantial details are available. Information on the use and abuse of alcohol among adolescents would be valuable in helping to define the magnitude of this problem. Such information would be useful in planning for adolescents, hopefully

to lower the frequency of alcoholism in a future generation of adults.

Herein is collected and summarized material relevant to alcohol abuse among the 12-17 year old population in Hawaii, with a view toward treatment of this problem. In particular, the degree to which alcohol abuse occurs among adolescents in Hawaii, and measures that are being taken to deal with this problem are discussed to ascertain whether further study is needed.

Definition

In 1948, Jellinek defined the "alcoholic" as one whose use of alcohol interferes noticeably with his physical, mental, or social functions. In 1951, a nearly identical definition was accepted by the World Health Organization.⁹ Since that time, the medical approach to alcohol use has advanced considerably. Alcoholism is now recognized (by both the AMA and WHO) as a progressive disease,¹⁰ which is frequently familial and possibly hereditary.¹¹ In the alcoholic, any small amount of alcohol will lead to an uncontrollable physical need, even though he may be fully aware of the dangers associated with excessive drinking. This is to be distinguished from "alcohol abuse" which is the use of alcohol as a "coping mechanism in dealing with the problems of life."¹²

As a progressive illness, alcoholism generally takes several years to manifest itself. Therefore, in dealing with excessive alcohol use in adolescents, it is more proper to speak of "alcohol abuse." It is evident that alcohol abuse can lead to alcoholism, although the exact relationship between the two has not yet been shown.

Studies indicate that alcoholism has developed in 5-10% of the estimated 95 million users of alcohol in the United States.¹³ Both the alcoholic and the alcohol abuser create a great burden on society, amounting to annual economic losses of over \$25 billion.¹⁴

Methods

Various agencies and individuals possibly having information on the use of alcohol among

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teenagers were surveyed throughout the four major counties of Hawaii, by telephone, mail, or personal interview. Each source was asked for (1) a description of their relationship with juvenile alcohol abuse; (2) statistical data; (3) personal observations and (4) recommendations.

Reference work was also done to: (1) determine the characteristics of juvenile alcohol abuse, including prevention, treatment, and rehabilitation; (2) review previous studies on alcohol abuse in Hawaii; and (3) locate literature which may be useful in dealing with juvenile alcohol abuse in Hawaii. Much of this work is reflected in the discussion and bibliography sections.

Sources providing data for this project included the following:

- I. *Health Agencies*
 - A. Hawaii State Department of Health
 1. Deputy Director's Office
 2. Health Education—Alcohol and Drug Abuse Section
 3. Research and Analysis Section
 - B. District Health Officers from the outer Islands
 - C. Hospitals and Clinics
 1. Queen's Medical Center Emergency Room
 2. St. Francis Hospital Emergency Room
 3. Hawaii State Hospital
- II. *Law Enforcement Agencies*
 - A. Police Departments from all islands
 - B. Liquor Control sources for all islands
 - C. Family courts
- III. *Social Work Agencies*
 - A. Department of Social Services, District Court — Honolulu
 - B. Office of Human Resources, Coordinated Drug Treatment Services System — Oahu
 - C. Kalihi-Palama Alcoholism Treatment Facility
 - D. Salvation Army Alcoholism Treatment Facility (SAATF)
 - E. YMCA Detached Counselors Program
 - F. Teenage Alcoholism Program
- IV. *School Related Sources*
 - A. State Department of Education — Health Education Office
 - B. University of Hawaii
 1. Department of Psychology
 2. Department of Psychiatry, Medical School, Alcohol Education Program

Results

Although literature on juvenile alcohol usage and abuse is plentiful, there are virtually no studies specific to Hawaii. A total of 44 sources were asked about adolescent alcohol abuse in Hawaii. Replies were received from 40 (91%). Of the 40 responses, 21 (51%) offered some appraisal

of the extent of juvenile alcohol abuse: 15 felt some problem exists; five indicated lack of sufficient evidence prevents conclusions; only one source suggested that no problem exists.

Seven of the 40 sources provided quantitative statistical information, and four gave statistical estimates. The seven sources providing quantitative data were: the police departments on Hawaii, Oahu, and Maui; the District Court Office in Honolulu; the Queen's Medical Center Emergency Room; the Salvation Army Alcoholism Treatment Facility; and the Department of Education. Statistical estimates were given by Hawaii State Hospital, St. Francis Hospital Emergency Room, Kalihi-Palama Alcohol Treatment Center, and the Teenage Alcoholism Program.

Surveys on the use of drugs, including alcohol and tobacco, were conducted by the Department of Education in 1971 and 1974. They indicated a rate of alcohol use comparable to mainland studies. Of seniors reporting regular use (monthly, daily, or weekly), 36% drank beer, and 29% drank hard liquor, according to the 1971 DOE study. This study was made on a sample numbering 12,900 students.

In 1974, the YMCA Detached Counselors Program conducted a survey on drug and alcohol abuse among its own clients, who were primarily involved with drugs other than alcohol, the program being funded to treat drug abusers. Among this population (N = 509), alcohol surpassed all other drugs being abused, with the exception of marijuana. Over a ten-month period from June, 1974, to March, 1975, the Queen's Emergency Room saw a total of 1,114 patients suffering from alcoholism. Among these were five youngsters aged 12-17. The St. Francis Hospital Emergency Room and the SAATF saw a similarly low number of juvenile cases. Hawaii State Hospital reported that no juveniles were seen in its alcoholism program. The Kalihi-Palama Alcoholism Treatment Center reports that over a 2½-year period about 10% of its approximately 4,000 clients were under 20, a high concentration being 19-20. The various county police departments report no dramatic increases in juvenile alcohol-related offenses. The District Court office in Honolulu reported a decrease in juvenile DWI arrests over the past two years. Two previous studies of alcoholism in Hawaii (Voss, 1961;¹⁷ Hare, 1974¹⁸) gave no specific juvenile data.

Nearly every organization and individual providing relevant comments expressed concern for alcohol abuse among teens in Hawaii. Nevertheless, effective treatment and educational programs designed for adolescents are not to be found.

At the present time, the teenage alcohol abuser or alcoholic has three choices: (1) he can apply to an adult treatment facility and, with parental

consent, receive treatment. Such facilities include the Salvation Army Alcoholism Treatment Facility, the Queen's and St. Francis Emergency Rooms. (2) He can go to one of the multipurpose youth facilities, e.g. Teen Challenge, Habilitat, or Waikiki Drug Clinic. These facilities report some degree of success. (3) He can go to Alcoholics Anonymous; however, the local teen group is no longer meeting regularly because of a lack of response.

Educational programs run by the State tend to be rather limited, consisting mainly of once-a-year presentations. Alcohol is included with other drugs in the DOE Health Education curriculum.

A few arrested alcoholics voluntarily run school programs. One woman has spent considerable effort in this area, having been invited to numerous schools and clubs. Her records show contact with approximately 10,000 students. The unfunded Teenage Alcoholism Program (TAP) is currently sponsored primarily by this lady, and is the only registered agency of its type in Hawaii. In addition to educational work and presentations, she also does voluntary counselling. She estimates that 31% of the adolescents in Hawaii have problems related to alcohol abuse. This is comparable to nationwide estimates given by Dr. Morris Chafetz, Director of the National Institute of Alcohol Abuse and Alcoholism.

There were two main reasons given for the alleged increase in teen alcohol use in Hawaii. Several sources mentioned the greater availability of alcohol over other drugs. Others spoke of a rapidly changing society, particularly on Maui. Agencies which work with adult alcoholics note that virtually all adults began their drinking in their teens, the midteens being a common starting age.

An Alcoholics Anonymous spokesman attributes the lack of teen response to the AA program to the difficulties teens have in recognizing the disorder in themselves; and to the fact that alcoholism, as a progressive illness, does not usually become of great individual concern until later in life.

Discussion

Data from the continental United States suggests that teenage alcohol abuse is a growing problem. At the present time alcohol surpasses all other drugs of abuse among teenagers in the nation.²⁰

In Hawaii, the lack of quantitative statistical information limits any definite conclusions concerning the presence and magnitude of juvenile alcohol abuse. However, there is considerable anecdotal opinion suggesting that such a problem does, in fact, exist. Fifteen of 21 respondents (71%) who commented on the extent of juvenile alcohol abuse in Hawaii indicated that they considered this a problem. Such opinion is obviously speculative and subject to personal bias.

The YMCA survey, which was limited in scope, was the only source of statistical information suggesting that teenage alcohol abuse is a major problem; however, this survey was directed towards individuals who are primarily involved with drugs other than alcohol. Thus, conclusions concerning alcohol use in this particular survey may not apply to the general adolescent population.

The police statistics show a very low rate of alcohol-related offenses among juveniles. However, the Maui Police Department notes that, although there have been indications from community sources of a problem in this area, most cases are not reported to the police. Similarly, the Hawaii Police Department wrote that it lacked the relevant statistical information to support or deny the existence of such a problem. The Honolulu Police Department noted that the decriminalization of public drunkenness necessarily limits the police view of the extent of juvenile alcohol abuse. The Family Court on Kauai suggests that police data may fluctuate depending on programs, rather than upon the problem itself. The decrease in juvenile DWI cases reported by the District Court does not necessarily indicate a decrease in alcohol abuse itself since the actual number of cases is small.

Information from emergency rooms also suggests a low rate of alcohol abuse; however, it has been agreed that the adolescent seeking help for alcohol-related problems is not likely to appear in the emergency room, particularly since parental consent is necessary for treatment.²¹ Westermeyer warned that:

"hospital and clinic data cannot be expected to indicate the magnitude of alcohol-related problems, since a small percentage of such problems surface to societal significance in medical settings."²²

The most complete pictures of juvenile alcohol use in Hawaii are given by the two DOE studies; however, these studies were highly inadequate in assessing alcohol abuse. Questions used on the survey were designed to measure frequency of use and attitudes towards use for various drugs. For heroin, frequency of use might be a sufficient criterion for abuse, but this is certainly not the case for alcohol. A student reporting daily use of beer, who in fact consumes one can a day with his dinner, may be considered not to abuse alcohol; conversely, a student reporting monthly use of liquor who consumes a quart of vodka once a month is a likely abuser. Alcohol abuse is a complex affliction, which depends not only on frequency and characteristics of use, but also upon problems associated with use.²⁴ Hence, although the 1974 study shows no substantial increase in alcohol use over 1971, rates of alcohol abuse are not clearly defined.

Recommendations and Summary

Because teenage alcohol abuse is a national

problem of epidemic proportions, and since the available data are insufficient to determine whether a problem of this type exists in Hawaii, what is needed at this point is a comprehensive assessment of alcohol abuse among juveniles in the State. This could be accomplished by a direct survey of the adolescent population, or indirectly through a survey of individuals who work with adolescents, e.g., school administrators and private physicians.

Furthermore, by comparing the national condition with that in Hawaii, preventative and therapeutic recommendations may be considered. Indeed, if a significant adolescent alcohol abuse is demonstrated in Hawaii, specific remedial measures should be considered: increased emphasis on education about alcohol; an on-

going surveillance program; implementation of adolescent treatment programs, and adolescent participation in planning and implementing such programs.

In Massachusetts an effort has been made to raise the minimum drinking age to 19.²⁵ Perhaps legislation of this sort should be considered in Hawaii in an effort to prevent alcohol usage in high school students.

Alcohol abuse among adolescents is a growing national concern. However, a survey of 44 agencies and individuals in Hawaii yielded no data capable of supporting or denying a problem. Therefore, it is suggested that a comprehensive survey be undertaken to determine the characteristics of adolescent alcohol abuse in Hawaii.

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RECOMMENDED READINGS

Adolescent Drinking Behavior

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Colonoscopy-Polypectomy Data Accumulation

ROBERT A. ROSE, M.D.*, *Kailua*

For the purpose of data accumulation, documentation, and preparatory rapid reviews in the instances of re-colonoscopy, a data sheet (Fig. 1) has evolved. Continuously in revision, its current format is presented for consideration.

Filling in the form is primarily the work of the endoscopy R.N. Although "Reasons for Study," are filled in to the best of her ability by my R.N., I think it essential that the physician review this to ascertain that the R.N.'s understanding of the pre-colonoscopy data is complete.

*Surgical Endoscopy Unit, Ambulatory Surgery Facility, Kailua Medical Arts, 407 Uluniu Street, Kailua, HI 96734.

Accepted for publication January, 1976.

The section, "Other Findings and Remarks," presents a joint responsibility. The first six items under this heading are obviously the sole responsibility of the colonoscopist. The last five items may be filled in by either the R.N. or the colonoscopist. The colonogram is best completed by the colonoscopist; this may be executed to his preference. It is my habit to make notations in the margins as to what was found, where, and to schematically note size, extent, and other particulars. Additionally, I usually trace the approximate position taken by the scope and make notations as to areas of difficulty or cautions. If well done, this provides a handy road map for the next scoping.

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15

The items, "Operative Report Dictated," and "Referrer Called," and "Letter Dictated" are the responsibility of the physician. They are checked off at the time of execution. "Bowel Preparation" can only be assayed by the colonoscopist.

Finally, the full data sheet is reviewed by the

endoscopy R.N. to make sure both she and the physician have taken care of all items. She then so notes, completes "Case Disposition," and files away this form, attached with the colonoscopy dictation and pathology report, for future reference.

FIG. 1.—Colonoscopy-Polypectomy Worksheet

COLONOSCOPY-POLYPECTOMY WORKSHEET																																							
<p>NAME _____ Sex _____ Age _____ Case# _____ Date _____</p> <p><u>REASONS FOR STUDY:</u></p> <p>Unexplained lower intestinal bleeding _____ Polypectomy-B.E./Pr. shows polyp _____ Follow-up of pt. who has had polyps _____ Inflammatory disease evaluations: _____ _____</p> <p>Colectomy for _____ Resolution of B.E. findings _____ Change in bowel habits _____ Family history of Colon Ca _____ Other _____</p> <p>BIOPSIES: No _____ Yes: _____</p> <p>Polypectomy: No _____ Yes: _____ Forcep _____ Fulguration _____ Pedunculated _____ Sessile _____ Size _____ Location _____</p> <p><u>OTHER FINDINGS AND REMARKS:</u></p> <table border="0"><tr><td>Yes</td><td>No</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td colspan="2">X-ray Dx. confirmed, clarified, rejected.</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td colspan="2">Unnecessary Laparotomy avoided</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td colspan="2">Cancer Dx'd: Missed by BE/PR</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td colspan="2">Polyps Dx'd: Missed by BE/PR</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td colspan="2">Bleeding Site identified</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td colspan="2">Endoscopy alone making diagnosis</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td colspan="2">Image Intensifier used</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td colspan="2">X-rays taken Still Pics _____</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td colspan="2">Stiffner used Cine _____</td></tr></table> <p><u>LOOP CONFIGURATIONS</u></p> <p>Alpha Maneuver: With I.I. _____ Without I.I. _____ Blind Alpha _____ "J" Transverse Colon Loop _____ "U" Transverse Colon Loop _____ Gamma Maneuvers _____ Others _____</p> <p><u>ANTI-SPASMODICS USED</u></p> <p>No _____ Yes _____ Type _____ Dosages _____</p> <p><u>COLONOSCOPY COMPLICATIONS</u></p> <p>No _____ Yes _____ Type _____</p> <p><u>ANESTHESIA COMPLICATIONS</u></p> <p>No _____ Yes _____ Type _____</p>	Yes	No	_____	_____	X-ray Dx. confirmed, clarified, rejected.		_____	_____	Unnecessary Laparotomy avoided		_____	_____	Cancer Dx'd: Missed by BE/PR		_____	_____	Polyps Dx'd: Missed by BE/PR		_____	_____	Bleeding Site identified		_____	_____	Endoscopy alone making diagnosis		_____	_____	Image Intensifier used		_____	_____	X-rays taken Still Pics _____		_____	_____	Stiffner used Cine _____		<p>REF. BY _____ In-Pt. _____ Out-Pt. _____</p> <p>Referrer Called _____ Letter Dictated _____ Operative Report Dictated _____</p> <p>Recent B.E.: _____ Type: _____ Report: _____</p> <p>Recent Procto _____ Report _____</p> <p>Recent Hemocults _____ Random _____ After No Meat, Hi. Res. _____</p> <p>Bowel Prep: In _____ E _____ G _____ F _____ P _____ Out _____ E _____ G _____ F _____ P _____</p> <p>Prep Modifications: _____</p> <p>Scope Used: _____ Level Reached _____ @ _____ Level Attempted _____</p> <p><u>Prior Abdominal Surgeries:</u></p> <p>No _____ Yes _____</p> <p>PATH DX: _____</p> <div data-bbox="1049 1493 1379 1893"></div> <p>PASSAGE PROBLEMS: _____ _____ _____ _____ _____ _____</p>
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JON WONG

Available now from your respective county medical society offices is the Worker's Compensation Fee Schedule of January 1, 1977, Regulation 31.

The suit filed by HMA requesting a preliminary injunction against that section of Act 219 (known as the malpractice insurance bill) of last year's legislature which requires a currently-licensed Hawaii physician to carry at least \$100,000 of malpractice insurance, or to provide evidence of financial responsibility of at least \$100,000 in order to keep his license to practice medicine and surgery, was originally scheduled for hearing January 12th. The hearing has been rescheduled for February 1, 1977.

Interesting to note that eleven medical specialty boards have received a total of 41 subpoenas from the Federal Trade Commission (FTC) ordering the boards to submit information on how boards operate, how members are selected, how certification is granted, and whether or not codes of ethics are used. This recent action reveals the FTC's continuing investigatory activity of medical and health care organizations. It might be wise for the FTC to begin with medical and health care organizations spawned by federal mandate or by federal dollars . . . or is the government afraid of what it might discover about government?!

Computer Consulting service for physicians begins operations at AMA Headquarters which will provide the services of a computer specialist who will travel to a physician's office to assess practice needs and possible computer applications, whether physician is on a computer system or not. This consultant from the AMA will act on a cost-plus-fixed-fee basis. For more informa-

tion, write Dept. of Computers in Medicine, AMA Headquarters.

Staff reorganization at HMA/HCMS has occurred. With the departure of Tom Thorson, executive staff level people were at a minimum, and with ever-increasing HMA/HCMS activities and PSRO responsibilities of staff, a review and evaluation of staff organization was undertaken. It was clear that additional executive staff was necessary to meet both existing and future needs. It was also clear that capable executive talent was available in the existing staff. Your Executive Director is pleased to announce the following: Andy Saranchock, Executive Assistant, is promoted to Assistant Executive Director; Tom Leineweber, Administrative Assistant, is promoted to Executive Assistant, Personnel Management; Les Ajifu, Accountant, is promoted to Executive Assistant, Financial Management; Irene Wong, Secretary to the Executive Director, is promoted to Administrative Assistant, Special Affairs; Becky Kendro, Staff Assistant for Legislation, is promoted to Administrative Assistant, Community Affairs; Bess Chang, Staff Assistant for Special Projects, is promoted to Administrative Assistant, Internal Affairs; and Paul Steward, Executive Editor of the HMJ, is promoted to Administrative Assistant for Publications.

Existing and new executive staff members have been given additional responsibilities and authority within the administrative structure of the combined staff. This reorganization has been in effect for a little over a month, and I am extremely pleased with the way the staff has responded. I am sure that you will find YOUR HMA/HCMS staff more than willing to serve you.

Physician wanted, either GP or FP, to take over established family practice in Hilo. Salary or financial arrangements negotiable. Position available mid-February, 1977, including complete medical facilities. Interested physicians contact R. H. Matsuura, M.D., 670 Ponahawai St., Suite 214, Hilo, Hawaii. Phone 935-2841.

Postgraduate course announcements

1. Sports Medicine for Primary Physician; March 8-12, 1977; Princess Kaiulani Hotel; Registration Fee of \$200.00. Sponsored by UH Medical School; co-sponsored by AAFP. Accredited for 18 hours of Category I. More information from Mr. Harold Brown, Hawaii Conference Services, P.O. Box 22670, Honolulu, 96822.

2. Course on Trauma, Endocrine Diseases, Exercise, and Antibiotic Selection; March 5-12, 1977; 9:00 a.m. to 1:00 p.m. daily; Maui Surf Hotel. Fee-\$100 for all or \$25/day. Sponsored by Kansas City Southwest Clinical Society in cooperation with Univ. of Missouri-Kansas City Medi-

cal School. Further information from Kansas City Southwest Clinical Society, 2220 Holmes St., Kansas City, MO. 64108.

3. Seminar on Patient Compliance. Will include physicians, nurses, pharmacists. Scheduled for Sunday, March 27, 1977, Ilikai Hotel. Co-sponsored by HMA, HNA, and Pharmacy Association and funded by Lederle Laboratories. More information will be coming soon.

Medical Assistant Workshop Registration.

The December 1976 Newsletter stated enrollment forms for the March 2nd and March 3rd Medical Assistants Workshop would be mailed to physician's offices during January. Inserted in this January issue of the HMA Journal you will find a registration form with detailed information on the workshop. Attendance quotas are limited. It is recommended that physicians desiring to send their medical assistant to the workshop should forward their check and completed registration form to the Bureau of Medical Economics, Honolulu, as early as possible. For further information call Harold Yamaguchi of BME staff at 536-9691.

HMA TDI Insurance Rate Increase. 1977

Temporary Disability Insurance Rates for physicians and their employees have been increased by Industrial Insurance Company of Hawaii from .58 per \$100 payroll to .77; an increase of 33%. Physicians are reminded that TDI benefits are paid only for the period of any employee's disability as certified by a physician. The 1977 increase for physicians and their employees is competitive for the class of employees insured.

Physician's Group Auto Insurance Terminates. Pacific Insurance Company has advised that the mass merchandising group auto insurance program for HMA physicians was discontinued as of January 15, 1977. By law, the program provides for one year of insurance at discounted mass merchandising rates after the termination date.

Hawaii's No-Fault Law and changes within the insurance industry are the primary causes of termination. It is now possible for members to obtain auto insurance coverage from other insurance companies at lower rates than in the mass merchandising of Pacific Insurance Company. This has resulted in a continuing deterioration in the program. As the individual policies terminate, your general agent will provide a quotation for the same coverage in the lowest rates possible.

Kahuku Sugar Mill Tour. Upon presentation of their respective 1977 County Medical Society membership cards, physicians as well as members of their families and guests will be entitled to

a 25% discount on the "World of Sugar" tour at Kahuku Sugar Mill during 1977. This hour long program includes admission to Kahuku's "Gallery of Sugar History," the multi-screen theater, and the guided mill tour.

"World of Sugar" tour rates for member, member's family and guests:

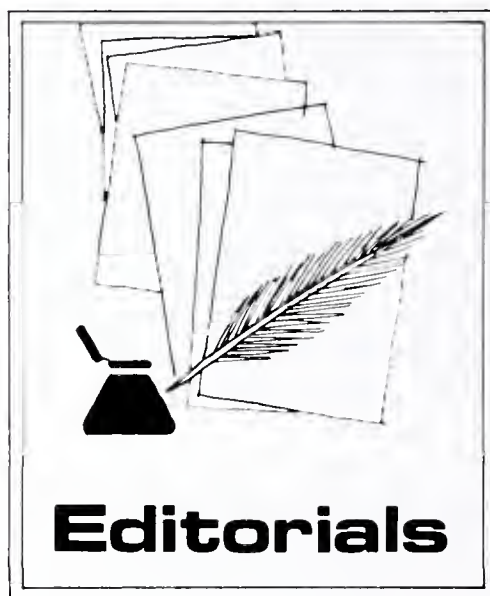
Adults (Reg. \$3.50) \$2.60

Kids 5-12 (Reg. \$2.25) \$1.60

Kids 4 and under Free

There is no charge for admission to all merchandise locations, dining areas and craft displays. People are free to stroll and shop from 10 a.m. to 6 p.m. everyday of the week. Guided tours run daily from 10 a.m. to 4 p.m.

Kahuku Sugar Mill has become Hawaii's newest cultural and entertainment attraction for families and visitors alike. Situated on Oahu's North Shore, opposite Kahuku Hospital, the Mill offers visitors a multi-media excursion into the ways and means of sugar making. Distinctive retail, restaurant, and refreshment locations have been blended into the nooks and crannies that once witnessed only the hubbub of spinning flywheels and gears, the hiss of steam valves and the hustle of mill workers.



Planning for health

A *Honolulu Advertiser* editorial (12/27/76) entitled "Flu and Confidence" provided considerable food for thought. The thrust of the editorial was directed at the public's growing concern with medical credibility: Which doctor is right? Does the profession speak with forked tongue?

There are essentially three categories of medical spokesmen: (a) The practicing physician himself—and lots of us are real primadonnas—or his professional societies and associations; (b) those in the "Ivory Towers" and those in the field of Public Health, and (c) the "Health Planners", many of whom are lay people.

Those of us in the first category have firsthand knowledge of people who are sick or injured, or who are in need of actual physical or

mental support and who need maintenance of reasonable good health. We do practice a lot of preventive medicine—or try to—by preaching good health habits, much of which falls on deaf ears. Because of our direct and practical role as “Providers” (horrible and impersonal bureaucratese!) of medical care to “Consumers” (ditto and worse because the word conjures up massive intake, greedy gorging, consumption at the oral end and overwhelming effluent at the anal end—and which one of us is not also a consumer?), we should be and are the most knowledgeable as regards “good health.”

In the second category, the Ivory Tower physician is a different breed of cat. True, some participate in direct patient care, but by and large, that physician is an academician, a theorist and a philosopher. He promotes good health by the book.

The Public Health physician, also in this second category, both nationally and locally, has a difficult time staying within his bounds. He joins his colleagues in the ivory towers in being largely a theorist. He goes by statistics (there is nothing more unreliable yet sacrosanct than the “cause of death” on a birth certificate, or a “diagnosis” on a claim form or on a report, or the occasional and partial reporting by busy practicing physicians to the Health Department of the incidence of Rubella, e.g.). He is the last to know if an epidemic of Flu has started. It was his input to President Ford that precipitated the immensely expensive and perhaps totally needless Swine Flu Program which may, in the long run, prove to be a failure as well.

Finally, in the third category, come the health planners, and the variety of professionalism and non-professionalism in their ranks is legion. Through the restrictions and regulations imposed by these people, lay people, the care of the sick and injured has become much more complicated, difficult and expensive. It is **they** who have become the providers, as they decide who should receive what: “No, even though there is a great need for more renal dialysis units, you may not have one in your hospital because, statistically, the hospital across the street has some that are not used to absolute capacity.”

Public Law 93-641 that is now engulfing the previous Hill-Burton, the Regional Medical Program (RMP), the Comprehensive Health Planning (CHP), was designed deliberately to exclude physicians and their input (and who else knows better what “health” really means?). The “providers”, with their sagacity, had their roles specifically minimized in the health planning process. “Consumers” (special provisions exist in the law to elevate them from know-nothings to some degree of educated intelligence!), on the other hand, were given the larger roles in decision-making for health.

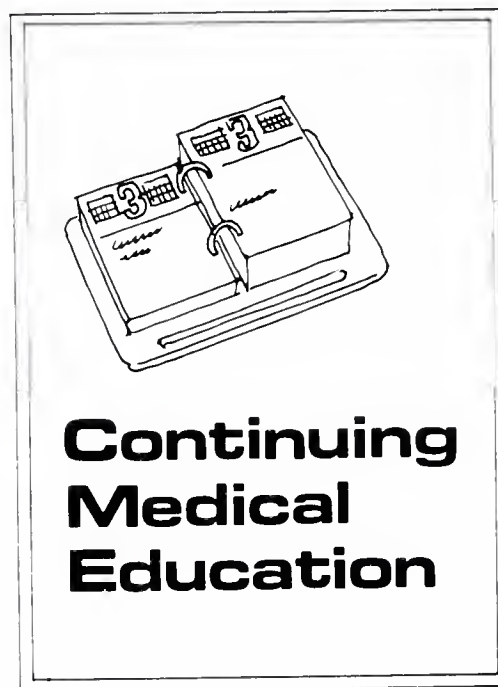
Here in Hawaii, this travesty on health planning is placed further into a state of confabula-

tion by the State, by its down-grading of the role of Sub Area Councils—those local grassroots committees of volunteers who are, at least, interested enough to dig into their regions’ health needs and then do something about them.

It is at this grassroots level, in the SAC’s, that some dedicated and perhaps gone-mad physician can have any input at all, and perhaps not even at this stage, if the State has its way.

It is no wonder the public is confused as to: Who speaks for health? The silver lining to this dark cloud, however, is that, hopefully perhaps, the public will choose correctly and fall back more and more on asking the erstwhile respected advice of the PMD—private medical doctor—the guy who really knows whether his patient should have the Flu shot or not!

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all “breaks”)

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Tuesdays, 10:00-11:30 a.m. at Queen’s or St. Francis. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Mabel Smyth Bldg. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 521-5064.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauaikeolani Children’s Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.

2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

(Contact CME Dept. for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m.
(Contact H.P. Stern, Capt, M.D., MC at 449-9742)

St. Francis Hospital

1. Medical Grand Rounds, Tuesday (4th & 5th) 12:30-1:30 p.m. Sull. IV Classroom
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Psychiatry for the Non-Psychiatrist, Tuesdays (2nd) 12:00-1:00 p.m.
7. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
8. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee

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No recession on the Strip

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BUREAU OF MEDICAL ECONOMICS - MEDICAL ASSISTANTS WORKSHOP
March 2 & 3 1977

"YOU, THE TELEPHONE MANAGER" and "MEDICAL COLLECTIONS MANAGEMENT" are AMA developed programs to aid and instruct medical personnel on telephone and collection techniques and office management using a video tape and role-playing case studies. The workshop includes instructions on appointment scheduling, handling the irate patient, collection techniques, and effectiveness when using the telephone.

The workshop is moderated by Karen Zupko of the AMA. Karen Zupko is a program director in the AMA's Department of Practice Management.

A communication's specialist, Ms. Zupko has conducted telephone management, public relations and collections workshop sessions for over 4,000 medical office personnel across the country in cooperation with 42 county medical societies and medical assistant organizations. In addition, she has participated in physician practice management seminars sponsored by the AMA for the National Health Service Corps.

Ms. Zupko, a journalism graduate of the University of Kansas, was named one of ten, "Innovative Women" in 1972 for her contributions to numerous university organizations.

She holds memberships in the American Association of Medical Society Executives, American Medical Writer's Association, Women in Communications, Inc., and is active in the Chicago Junior Association of Commerce and Industry.

Registration will begin at 8:15 a.m. on both days for the "YOU THE TELEPHONE MANAGER" and 11:45 a.m. for the "MEDICAL COLLECTION MANAGEMENT" at the Ala Moana Banquet Hall. Morning sessions will be limited to 50 participants and 75 for the afternoon sessions. Lunch at 12:00 noon will bring both the morning and afternoon sessions together for a presentation by BME's attorney, Mr. Clifford Miller from the law offices of Rice, Lee and Wong.

Reservations are accepted on a first-come, first-served basis. Please fill out the registration form below and return to the Bureau of Medical Economics.

PLEASE DETACH

REGISTRATION FORM

BUREAU OF MEDICAL ECONOMICS - MEDICAL ASSISTANTS WORKSHOP

Please enroll _____ persons. Indicate desired attendance date.

NAME	MARCH 2nd (Wed)		MARCH 3rd (Thur)	
	A. M.	P. M.	A. M.	P. M.
	You, The Tele Mgr	Collection Mgmnt	You, The Tele Mgr	Collection Mgmnt
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

MEDICAL OFFICE: _____

PHONE NUMBER: _____

Mail check with registration to: BUREAU OF MEDICAL ECONOMICS
111 North King Street Suite 309
Honolulu, Hawaii 96817

Single Session: \$15.00
All Day Session: \$25.00

TOTAL AMOUNT ENCLOSED: \$ _____

meetings, 1st Monday, 7:30 p.m. & 2nd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Honolulu County Medical Society and Local Hospitals, Honolulu

Type: 1, 1 hr/day, 1 day/mo from 12 mos

Fee: None Methods: AV, O, Pan

Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

Type: 1, 1 hr/day, 1 day/mo for 8 mos

Fee: None Methods: AV, Clin C, O, Pan, R

Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

Jan. 27-March 31, 1977 "Interdisciplinary Health Team Development"—Manoa Campus, Sch. of Med. Thurs. 6-9 p.m. 8 sessions, 24 hrs. Cat. 1. Contact: John Watson, M.D. 948-8895 or Mrs. Bermsk 948-7053.

Jan. 31-Feb. 5, 1977 Perinatal Med.-Royal Lahaina Htl.-Maui. Contact: Univ. of Southern Cal. Sch. of Med, 2025 Zonal Ave. LA 90033.

Feb. 1, 1977 "Update on Diabetes Mellitus"-Wahiawa Hsp. Dining Rm., Tuesday, 12:30 p.m. Speaker: Dr. Willard Miyahira. Contact: CME Dept-Wahiawa Hsp.

Feb. 3, Mar. 3, Apr. 7, 1977 "Fundamentals of Echocardiography"-Dr. V. E. Friedewald, Jr. Lecture One; 12:30-1:30 p.m. HI Heart Assoc & Queen's Med. Cntr. Hono. Med. Group-Queen's Med. Cntr. Nalani 1 Conf. Rm. Contact: Ellie Morris, Cardiac Lab. Queen's ph. 538-9011 Ext. 535.

Feb. 5, 1977 "Acute Surgical Abdomen-Part 3"-Acute Cholecystitis"-Dr. Marcio Aknio. 7:30 a.m. Kaiser Pac.Aud.-Kaiser Hsp. 1 hr. Cat. 1. (Contact CME Dept. for further info.)

Feb. 8, 1977 "Diabetes in Pregnancy"; "Management of the Neonate"; "Diabetes in the Pediatric Age Group & Its Management"-Tuesday, 12:30 p.m. Wahiawa Hsp. Speakers: Drs. John Kim & Azucena Ignacio. Contact: CME Dept.-Wahiawa Hsp.

Feb. 8-10, Mar. 8-10, Apr. 12-14, 1977 "Basic & Advanced Cardiac Life Support Cert. Courses for Phys. Staffing Emergency Rooms" Am. Heart Assoc-HMA Emergency Med. Serv. Program & ACEP-Hawaii. St. Francis Hsp., Ward 2B-Ed. Auf. 2230 Liliha St. Hono. 3 days-22 hrs. Cat. 1 AMA: AAFP-24 hrs. & ACEP Cat. 1-22 hrs. Contact: J.K. Sims, M.D. HMA/EMS: 1301 Punchbowl-Hono. 538-9011 ext. 471.

Feb. 12, 1977

Radiation Biology-Drs. Boyer & DeMare-Kaiser Pac.Aud.-Kaiser Hsp. 1 hr. Cat. 1. 7:30-8:30 a.m. (Contact CME Dept. for further info.)

Feb. 15, 1977

"Management of Diabetic Complications & Other Concomitant Medical and/or Surgical Problems in the Diabetic Patient"-Tuesday, 12:30 p.m. Wahiawa Hsp. Speaker: Dr. Dudley Seto. Contact: CME Dept.-Wahiawa Hsp.

Feb. 19, 1977

Radiotherapy-Drs. Boyer & DeMare. Kaiser Pac.Aud.-Kaiser Hsp. 7:30-8:30 a.m. (Contact CME Dept. for further info.)

Feb. 20-25, 1977

"Advances in Patient Care" 5 day Conf. 24 hrs. Cat. 1. Maui Surf Hotel, Kaanapali Beach. Write or call: 315 University Dist. Bldg. 1107 NE 45th St., Seattle, Wash. 98105-(206) 633-0505.

Feb. 22, 1977

"Hyperosmolar Nonketotic Diabetic Acidosis & Coma" "Hypoglycemia: Significance & Management"-Tuesday, 12:30 p.m. Wahiawa Hsp. Speaker: Dr. Werner Schroffner. Contact: CME Dept.-Wahiawa Hsp.

Feb. 26, 1977

"New Concepts in the Evaluation of Neoplastic Lymphoproliferative Disorders"-Dr. A. G. Scottolini. Kaiser Pac.Aud.-Kaiser Hsp. 7:30-8:30 a.m. 1 hr. Cat. 1. (Contact CME Dept. for further info.)

Feb. 27, Mar. 12, 1977

Visiting Professor of Oncology. American Cancer Society, HI Div., Inc., 200 N. Vineyard Blvd. Hono. 96817. Ph. (808) 531-1662 for further info.

Mar. 5-9, 1977

Oncology Clinics-Unv. of Minn. Med. Schl. Box 293, Mayo Mem. Bldg. Minn. 55455. Held at Hyatt Regency Hotel, Honolulu. Fee \$250.

Mar. 7-10, 1977

"Trauma", "Endocrine Diseases", "Exercise", and "Antibiotic Selection". Kansas City SW Clin. Soc. 2220 Holmes St. Kansas City, Mo. 64108. Co-Sponsor: Unv. of Mo.-Kansas City Schl. of Med. Held at Maui Surf Hotel, Maui, HI Fee \$100.

Mar. 8-12, 1977

Sports Med. for the Primary Phys.-Unv. of HI Schl. of Med. 1960 East-West Rd., Hono., HI 96822. Held at Princess Kaiulani Hotel, Hono. Contact: Harold Brown, P.O. Box 22670, Hono. 96822. Fee \$200.

Mar. 13-19, 1977

Diving Med.-Undersea Med. Soc, c/o Professor E. Beckman, Unv. of HI Conf. Cntr. 1960 East-West Rd., Hono., 96822. Held at King Kamehameha Hotel, Kailua Kona, HI. Fee \$250.

Apr. 4-9, 1977

Adolescent Medicine-Unv. of HI Schl. of Med., Dept. of Pediatrics, 226 N. Kuakini St., Hono., 96817. Held at 1319 Punahou St. Hono., 96814. Fee \$40.

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Order of the Golden Rule, Hawaii Funeral Directors Association

Apr. 16-23, 1977 Emergency Medicine-Univ. of So. Calif. Schl. of Med. 2025 Zonal Ave. Los Ang. 90033. Held at Kona Surf Hotel, Kona, HI. Gail Anderson, M.D. Prof. of Emergency Med.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1976 Supplement to JAMA or call the HMA Office.



**Hawaii
Academy of
Family
Physicians'
Newsletter**

J. I. FREDERICK REPPUN, M.D.

NOTA BENE!

Don't forget the Annual Meeting, Election of Officers, Installation by President Les Huffman of AAFP, and the Adoption of the Revised Bylaws on *Saturday, 15 January, 6:00 PM at The Willows.*

New Members—**Kenneth H. Kern MD** is a new Practicing Affiliate member; a new Student member is **Fred H. Royce Jr.** of the Class of '77 at the UHSM. We welcome you.

Membership—according to the printout from Hq as of 30 Nov 76, we had a total of 124, of which 57 are Active, 11 Active-Exempt and 1 Sustaining for a total of 69 full-dues paying members; we have 7 Practicing Affiliate and 1 Resident Affiliate, 5 Inactive, 12 Life and 30 Student.

News of Members—**Fred Dodge** finished the Marathon in 5 hours! Shows what a busy practitioner he is. **Don Farrell** got his face onto the "Planning for Health" publication of the Kaiser Foundation Health Plan. Another Jimmy Carter smile except for mustache and hornrims. He is head of their Family Practice Hospital Department and Chairman of the Dept.

at UHSM. We're proud, Don! **Cass Jasinski** is resigning because he will no longer be in Family Practice; he will be full-time FAA physician in Aviation Medicine; he is also State Air Surgeon with the Hawaii Nat'l Guard. **Doris Jasinski** will not grace our annual meeting, choosing instead to go with Cass to the Nevada Ski-AFP meeting at Lake Tahoe. At the December Council meeting, half had had the Swine Flu shot; half had not. Oh Ye of little faith!

HMSA—under the persistent push-to-shove by **Mary Glover**, the Council has made contact with the HMA. The latter's new president, pediatrician Cal Sia, has picked up the ball and is running with it to the State Insurance Commissioner. It seems that "Pars" physicians and "Non-pars" are being paid by HMSA on different fee schedules. More later.

Our treasury received an unexpected \$56 from *Ohio & Connecticut Core Content Review* as a refund because 14 members signed up for the "P" credit 6-month course—representing 24.6% of our membership. Hawaii thus placed 5th, Alaska being first with a 47.7% enrollment in relation to Active membership.

New Education Chairman—**Felix Lafferty** has agreed to take on the chairmanship of the Education Committee, relieving **Fred Dodge** of a 5-year job very well done.

Cancer Report—How many Active members participate in the AAFP Cancer Monitor? The September 1976 report's "What We Found" listed 4,094 cases reported by members complying. By age groups: Acute Leukemia led in the 0-20 year bracket, cervical cancer (3 times the incidence of breast cancer) in the 20-30's, breast cancer (nearly twice the incidence of lung) in the 40-50's, colon-rectum by far in the 60-70's and those over 80. Cancer of the breast is the most frequent major malignancy with colon-rectum second. Ovarian cancer is a silent killer and accounts for more deaths than cervix and uterus combined.

A HAPPY NEW YEAR TO ALL!!



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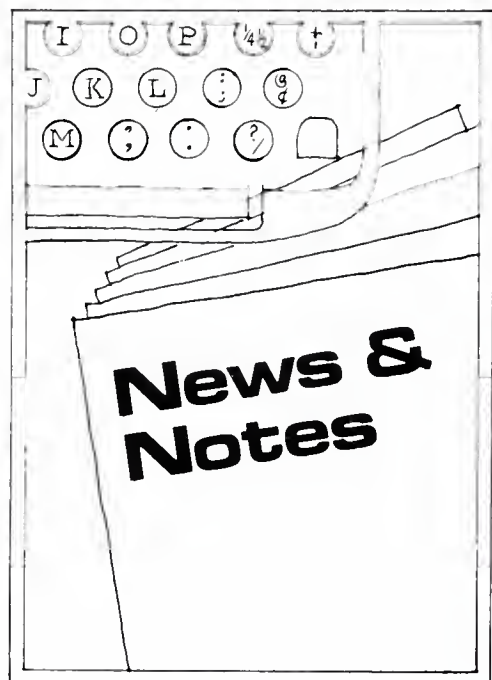
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- (4) determination if certain patient categories are at *specific* risk when exposed to burning sugar cane smoke (e.g., asthmatics?)

All of these studies would help to identify the persons at risk for developing allergic reactions to sugar cane smoke, whether tourist, resident, or resident sugar cane worker. Studies on specific treatment modalities would assist physicians in patient management or referral. This preliminary work of Dr. Lehman is an asset to allergists, pediatricians, emergency physicians, and internists in Hawaii and other areas of the world that grow sugar cane.

J. K. SIMS, M.D.



HENRY N. YOKOYAMA, M.D.

Professional Moves

The Year of the Snake is upon us but we are still clearing up the Year of the Dragon . . . In November, urologist **E. Lee Simmons** associated with fellow urologist **John Edwards** at Suite 728, Pan Am Building and at the Pearl City Medical Center, 880 Kam Hwy . . . Pediatrician **Donald Fox** joined the Kaiser group at 94-235 Leoku St, Waipahu and OB man **Russell Bachman** joined the group's 1697 Ala Moana Blvd offices . . .

In December, surgeon **Raymond Fujikami** joined the Medical Specialty Clinic at 1314 So King St (The American Security Bank Bld) . . . **Clifford Chang** likewise relocated to the American Security Bank, Suite 415 and so did ophthalmologist **Lorene Anastasi** into Suite 417. Pediatrician **Reynold Shirai** moved into Kapiolani Childrens' Medical Center, **Ronald Perry** relocated to 2302 So Beretania St, and **Charles C. Ching** (general, thoracic and cardiovascular surgeon) moved into 1481 So King St, Suite 339 (Across the street from **Charles T.H. Ching**, internist and no relation) . . . **E. Wayne Dutton** relocated from 888 So King to Diamond Head Tower, 4th Floor, Hemmeter Center . . .

On the Big Island, **R.S. Carvalho** relocated to 261 Waiuanue Ave (Dr. Jenkin's former office) . . . On Maui, GP **Donald Altfeld** opened at Lahaina Square, 840 Wainee St, Lahaina . . . On Kauai, pediatrician **Linda Weiner** joined **Ronald Hattos** /sic/ at 3897 Hanapepe Rd . . .

Benjamin Lambiotte, former medical director of Waimano Home was appointed City & County physician succeeding **Paul Gebauer** who resigned over a year ago. We understand acting C&C physician **Sam Yee** is recuperating from a recent heart surgery . . .

On to the Year of the Snake . . . In January, dermatologist **Frederick Maag** relocated to Suite 368, Alexander Young Bld

(former office of Harold Johnson). Plastic surgeon **Michael Weiner** opened offices at the Aiea Health Cooperative, 99-185 Moanalua Rd and the Kailua Medical Arts Bld, 407 Uluniu St. Eye man **Donald Depp** associated with the Fronk Clinic . . .

Life In These Parts . . .

"Dr. **Donald Depp** is back in the Islands and says he plans to stay . . . Some years ago the surgeon began to specialize in eye surgery in hopes of saving his daughter's failing eyesight. He wasn't able to, unfortunately, but many others have been aided since then." (From Dave Donnelly's column)

A \$100 contribution by Robert Hamblin (his 3rd) pushed the Samuel R. Wallis Scholarship fund over the \$10,000 mark. The fund was established in 1973 and donations are tax deductible. Checks can be made to the fund c/o G.N. Wilcox Memorial Hospital . . .

On the Volcano Isle, **Richard Adler** (Hilo Medical Center) and a Dr. **Edward Fujimoto** (Hilo College) are coordinating the community dialogue project, "Community Perspectives on Medical Self-Help." The project is designed to help doctors better understand patients of different ethnic backgrounds, to help patients have confidence in medical self help and some of their own cultural orientations toward medical self help, and to help improve the communicative interaction between doctors of western medicine and patients of a multicultural orientation . . .

In November, "Dr." Albert Michaely (Honolulu acupuncturist operating the Ear Staple Clinic) who claimed that ear staples are "a guaranteed method to lose pounds and stop smoking" was finally prohibited from practicing acupuncture in Hawaii after a full year of court litigation . . .

Hunky Chun and his family of eight affectionately known as the "Hunky Bunch" have participated in 4 marathons including the 1974 Boston Marathon and 3 members hold U.S. age group marathon records viz Daven 12, mother Connie 48, and June 14 (who is also State cross country high school girls' champ). We learned that Connie (former assistant nursing director at St Francis Hosp) is a 2nd year law student at U of H . . .

A new federal law restricts the recruitment of foreign med school grads by hospitals effective Jan 10. Local hospitals are med school affiliates and therefore are not affected. The restriction is part of a comprehensive law approved by Congress last October designed to enable American medical schools to produce enough physicians to meet national needs by 1980. The new regulations require everyone to take Parts I & II of the National Boards, and eliminates the preferred status of immigrating foreign med school grads . . .

Miscellany

A lawyer, a minister and a doctor went sailing off Waikiki and were swamped several miles from shore . . . They clung to the overturned hull, but with nightfall approaching and no rescue in sight, they decided to draw straws to see who would swim for help . . . The lawyer drew the short end (only because this is a joke) and he started resolutely to swim . . . Suddenly two large sharks began to circle him several hundred yards out . . . The minister prayed, "Oh, Lord! Help our friend in his time of need . . . etc . . . etc . . ." When he finished, the lawyer was hanging onto each shark's dorsal fin and being escorted toward shore . . . The minister loudly acclaimed the power of the Almighty. The doctor was less impressed . . . "It's simply a matter of professional courtesy," he said tartly . . . (As told by Tad Iwanuma)

Item gleaned from the Kuakini Makai III bulletin board: "Women's faults are many . . . Men have only two . . . Everything they say and everything they do."

Elected, Appointed, & Honored

Popular Front: QMC pathologist **Ann Catts** became the first woman president of the Honolulu County Medical Society. **Patrick Walsh** is president-elect, **Walter W.Y. Chang** secretary and **John Edwards** treasurer. Elected to the Board of Governors were **James Ball**, **Henry Fong**, **Elmer Johnson**,

Calvin Kam and **John Watson**. Alternate board members elected were **Ed Boone**, **Bernard Fong**, **Myron Shirasu** and **Neal Winn** . . .

National Front: **Max Botticelli** was one of 275 new fellows named to the American College of Physicians at a recent meeting in Philadelphia . . . **Michael Dougherty** became a fellow in the American College of Cardiology . . . **Clarence Burgess**, retired Straub cardiovascular surgeon was recently honored by the University of North Dakota with the alumni's Sioux Award . . . C.M. is also a founding member of the Hawaiian Malacological Society and a recognized authority on sea shells . . . **Bernard Fong** was appointed by the HEW Secretary to serve a 4 year term on the 18 member National Heart, Lung and Blood Advisory Council which serves under the National Institute of Health. Bernard is governor of the American College of Physicians, fellow of the American Board of Chest Physicians, and a member of the American College of Cardiology . . . **John Watson**, U of H med school professor of surgery and first VP of HMSA was elected president of the Western Conference of Prepaid Medical Service Plans . . . **Yorio Wakatake** was named charter president of the U.S. Aikido Federation recently formed in New York City. Yorio is president of the Hawaii Aikido Association which includes 15 clubs on Oahu alone . . .

Local Front: Chest surgeon **Ignacio Torres** was elected president of the Hawaii Thoracic Society succeeding **Philip Fotio** who served two terms. **Michael Light** was elected VP and **Azucena Ignacio** secretary-treasurer . . .

Chittendenisms . . . (Gleaned from our KCH Poison Control Center director)

re Mushrooms: There are *old* mushroom hunters, but no *old bold* mushroom hunters . . . In Hawaii, we have a wide variety of toxic mushrooms . . .

re Librium and Valium: The lethal dose is 4,900 mg . . .

re Acetophenacetin: Twice as toxic as aspirin . . . There is no respiratory alkalosis phase but it causes true metabolic acidosis and liver damage . . .

STAGES OF ADULTHOOD (As told by Bernard Fong to Walter Young)

- Early adulthood: "I had a great date last night."
- Middle adulthood: "I had a great dinner last night."
- Older adulthood: "I had a great BM last night."

Sportsmen . . .

Honolulu Marathon, 1976

The Honolulu Marathon, 1976 began at 6:30 am Dec 12 with over 1,500 aspirants running the 26-mile course from Aloha Tower to Hawaii Kai and back. **Jack Scaff**, president of the Marathon Association sez: "We take anyone. The only condition is a willingness to run and a certain amount of preparation. There is no age limit, no time limit, no speed limit." Co-founder John Wagner commented on the origin of the Association: "We realized there was no way the average person could learn long distance running . . . Too, we were bored running by ourselves . . . So we started a runner's clinic—which formed the nucleus for the marathon." To prepare for the marathon, Kaiser pathologist **Jim Bennett** (who is a young 60) runs to work and back from Kahala to Kaiser 3 times a week and cycles the distance on the other work days . . . Jack Scaff claims long distance running is addictive . . . "Otherwise why would a person be willing to train for a whole year just to run a race for a few hours . . . Running is a recreation of primeval child's play. It recaptures the primitive heritage of man. We accept the fact that man is a hunting animal. Man is the best of the long distance runners. Man is probably at his biological peak when he is running." Star^o Bulletin columnist Dave Donnelly reported that the Kaiser contingent includes **Alex Roth**, **Bob Oldt**, **Buddy Chun Ming**, **Raj Mehta**, and **Ray Stoneback** . . . The Honolulu Medical Group, the Honolulu Marathon Association and the American Jogger's Association hosted a pre-marathon "Meet and Greet the Speakers and World Class Runners" carbohydrate loading party on Friday, Dec 10 with pizza, beer and other goodies by way of storing up extra energy . . . Jack sez Hawaii is the runningest state in the union, ie 80 runners

per 100,000 population. Oregon is 2nd with 19 per 100,000 while the rest of the states average 9 runners per 100,000 population . . .

Annual St. Francis Hospital Golf Tournament (Held Mid Pac CC, Sep 1)

The tournament chaired by **Alvin Paraz**, last year's winner had 50 participants including a guest flight. Low net winner was **Paul Lin** who shot 84-21-63 and won the honor of being next year's chairman . . . Paul will be ably assisted by **Quintin Uy** and **Ray Fujikami**. Ray Fujikami was high gross winner with his 110 while Quintin Uy was low gross winner with his 78. Net 66's were **Chew Mun Lum**, Quintin Uy and **Manuel Abundo**. Net 68's were **Bill Dang**, **Alvin Paraz**, and **Francis Soon**. **Herminio Mercado** was alone at net 69. Net 72's included **Richard Ho** and **Thomas Min**. Net 73's were **Francis Au**, **Catalino Cachero** and **Winfred Lee**. Net 74's were **Henry Fong**, **Al Chun Hoon**, **Ernesto Orinion**, **Ruben Mallari**, **Ed Lau**, **LQ Pang**, and **Norman Nakamura**. Net 75's were **Richard Mitsunaga**, **Gordon Chang** and **Daniel Whang**. Net 76's were **Paul Tamura** and **Fred Lam Jr** and at net 77 were **Francis Oda** and **Winfred Chang** . . . We shan't mention any higher nets for they may prefer to remain anonymous . . .

Doctor Patients . . .

Vernon Jim had his appendix out recently at QMC . . . The day he became ambulatory, Jim was down in the ER resuturing a bleeding eye on one of his patients . . . Then he promptly hopped back into his hospital bed (As reported by **Fred Rep-pun**)

Three physicians recently had surgery at Kuakini Hospital on the same day . . . **Akira Kutsunai** had his colostomy removed, **Roy Iritani** had a prostatic biopsy by **Shigeo Yamamoto**, who several hours later was himself explored for GI obstructive symptoms . . . (As reported by **George Suzuki**)

Stemmy Says:

Whenever there is unexplained anemia or an elevated CEA, there should be a routine gastroscopy even when the upper GI series is negative . . . A recent review of 350 autopsies at Kuakini revealed 5 cases of unsuspected gastric CA (mostly in Japanese) . . .

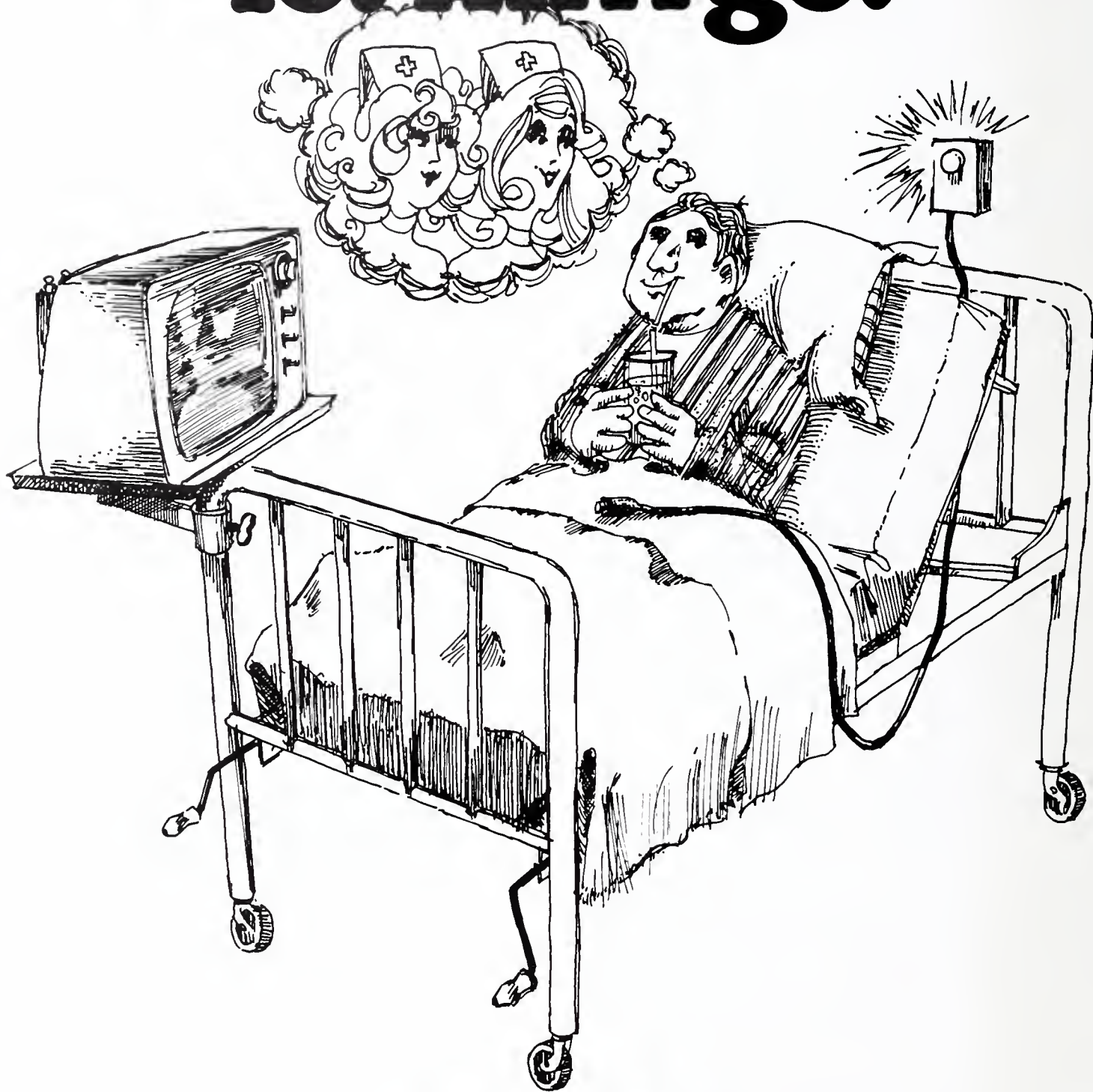
Miscellany

"Men with receding hair lines are thinkers . . . Men with a bald spot are lovers . . . Those with both just think they are lovers . . ." (A Frank Fukunaga quote heard by George Suzuki)

Our "Angels"

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Hawaii Medical Service Association

FEBRUARY 1977
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Hawaii Medical Journal

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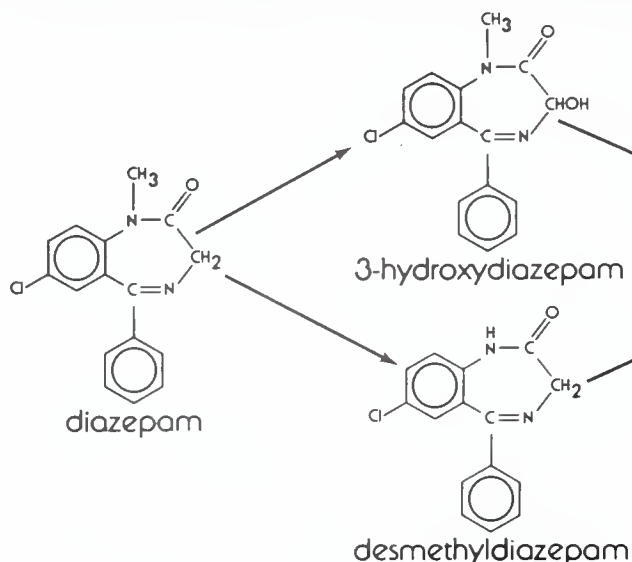
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to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated:

Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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*** Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" Effective: For controlling bronchospastic disorders.
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The potentiating action of hydroxyzine, although mild, must be taken into consideration when the drug is used in conjunction with central nervous system depressants; and when other central nervous system depressants are administered concomitantly with hydroxyzine their dosage should be reduced.

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How Supplied: Marax Tablets are available as light blue, scored tablets in bottles of 100 and 500.

Marax Syrup is available in pints and gallons, and should be dispensed in amber-colored bottles.

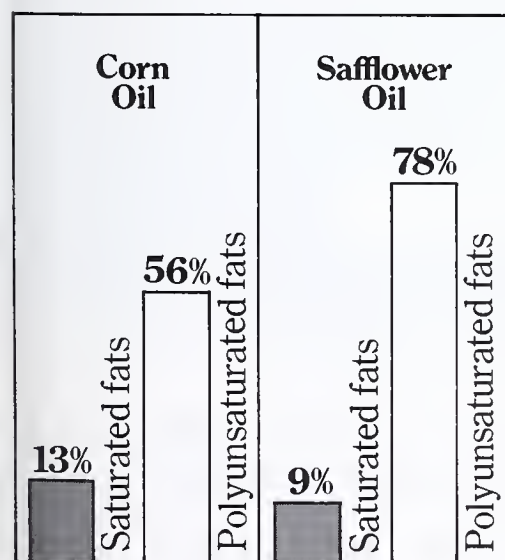
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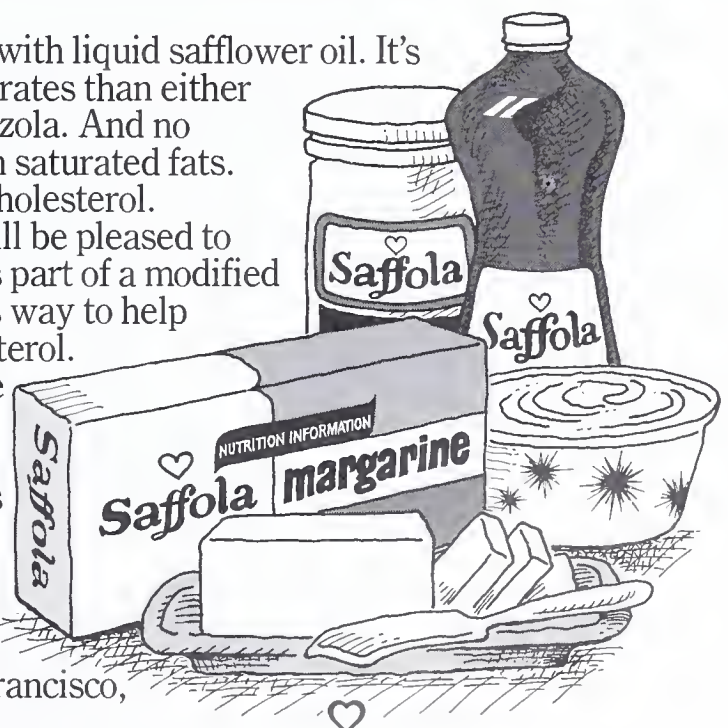


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Precautions: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce

adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: Codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients: Administer with caution to certain patients such as the elderly or debilitated and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequent: lightheadedness, dizziness, sedation, nausea and vomiting; more prominent in ambulatory than nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Others: euphoria, dysphoria, constipation and pruritus.

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For information on symptoms and treatment of overdosage, see full prescribing information.

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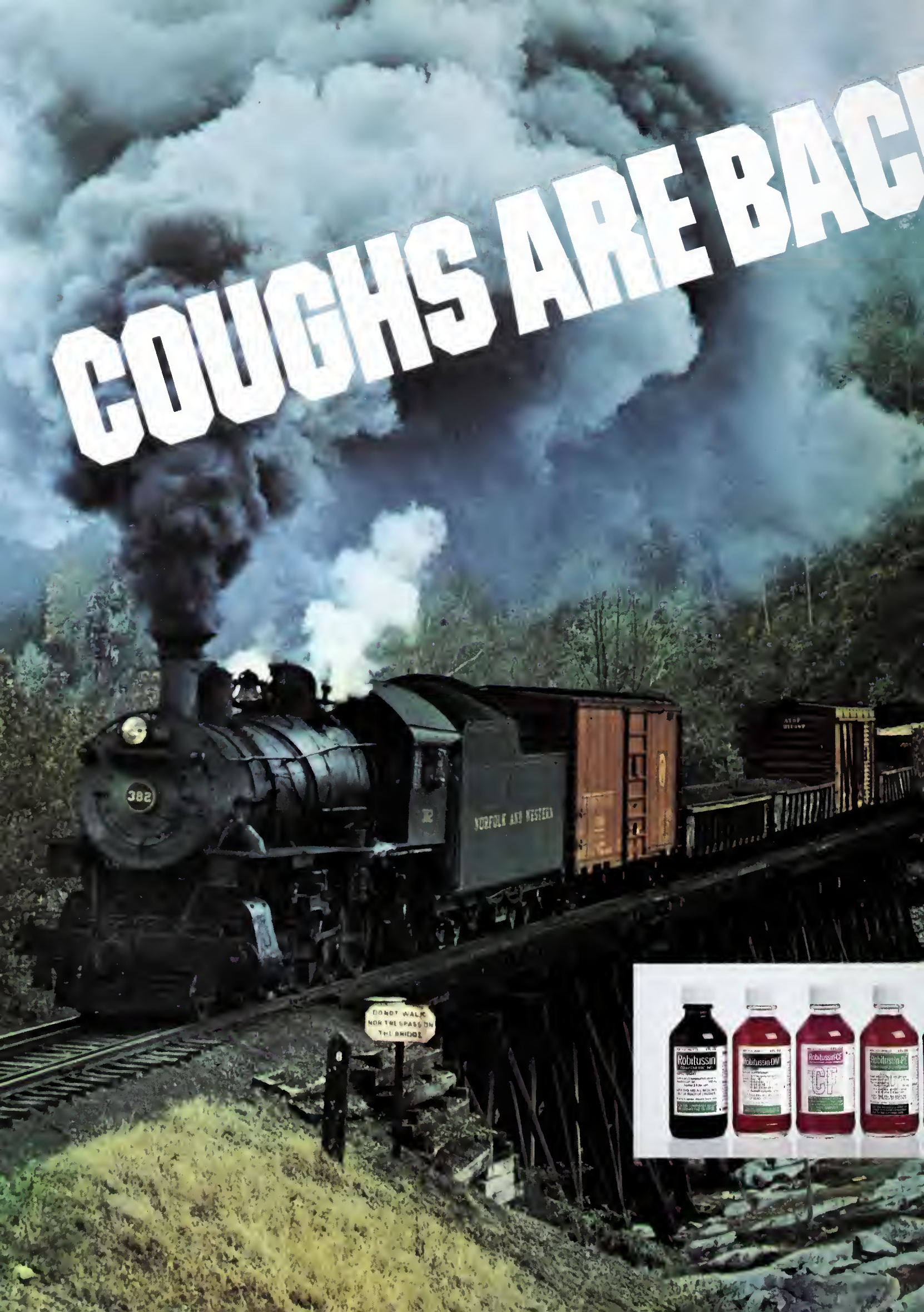
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Powdered opium, USP	24.0 mg.
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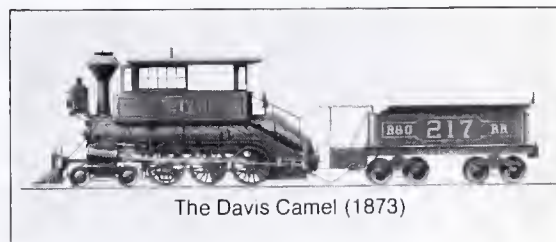
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Does Kinin Released by Pineapple Stem Bromelain Stimulate Production of Prostaglandin E₁-like Compounds?

GEORGE E. FELTON*, *Honolulu*

Since Heinicke and Gortner¹ announced in 1957 the preparation of pineapple stem bromelain, about 200 scientific papers have appeared on the medical applications of this enzyme mixture. These reports claim positive responses in a wide variety of conditions and indicate the following effects:

1. Stimulation of muscle contractions.
2. Smooth muscle relaxation.
3. Inhibition of blood platelet aggregation.
4. Enhanced antibiotic absorption.
5. Cancer prevention and remission.
6. Burn debridement.
7. Prevention of epinephrine induced pulmonary edema.
8. Anti-inflammatory action.
9. Ulcer prevention.
10. Sinusitis relief.
11. Shortening of labor.
12. Enhanced excretion of fat.
13. Appetite inhibition.

The wide variety of responses has led to the suspicion that the reported results may be due to psychological rather than physiological effects. Although this possibility cannot be ruled out for some of the published reports, there are adequate data to verify that at least one bromelain component has truly remarkable properties. The purpose of this paper is to present a unifying concept that could explain all of the above reported results.

Previous attempts have been made by Martin *et al*² to explain bromelain's anti-inflammatory action and by Nieper³ and Gerard⁴ to explain its anti-cancer action. Martin and Nieper based

their explanations on the known proteolytic action of bromelain, and their concepts required that this approximately 33,000 molecular weight enzyme be absorbed into the blood stream and transported throughout the body.

It is now known that the pharmacological action of bromelain is not produced by the protease, and evidence that a sizeable enzyme could be absorbed into the blood circulation in significant amounts has not been convincing. On the other hand, Gerard rejected the concept of absorption of a large enzyme and proposed that bromelain action was due to the release of one or more hormones in the duodenum or distal small intestine or both. He also proposed that the hormone released had anti-inflammatory and cell-division—controlling properties. Gerard's work has not yet received recognition for the pioneering effort that it represents. Gerard recognized the limitations of his research: as he stated in his introduction, "This report might appear premature; however, in spite of the small number of observations it seemed to me important because it suggests a new therapeutic approach to cellular anarchy, a problem not yet solved. I did not feel that I could assume the responsibility to withhold information which could trigger research to isolate an anti-cancer principle, which according to me is contained in bromelain."

The proposed hypothesis to explain the physiological effects of bromelain is that a minor enzymatic component is responsible for the release of a kinin which is capable of activating several enzyme systems in the body. Katori *et al*^{5,6} have demonstrated that bromelain activates plasma kallikrein and releases a plasma kinin in rats. Katori has also observed a similar action in rabbit plasma *in vitro*. Several groups of investigators, Ferreira *et al*⁷ and McGiff *et al*,⁸ have demonstrated that bradykinin stimulates various

*Castle & Cooke Foods, Retired, P.O. Drawer 3380, Honolulu, Hawaii 96801.

Accepted for publication February, 1976.

body organs to produce significant quantities of prostaglandin E-like compounds (PGE). It has been proven that these compounds are related to PGE₂. Since many bromelain responses definitely resemble responses to PGE₁ and not to PGE₂, it would appear that the kinin produced by bromelain stimulation is not bradykinin but another kinin, which is an activator for production of PGE₁-like compounds. It also appears that the kinin produced by bromelain may activate certain enzyme systems in addition to those responsible for PGE₁-like compounds.

A single bromelain component may be responsible for all of the unique pharmacological properties of this enzyme mixture; however, this point has not yet been established experimentally. An active bromelain component has been isolated and purified by Houck⁹. The properties of this compound have not yet been completely defined but it is an enzyme of about 45,000 molecular weight. It is more stable to acid and heat than is the main protease fraction of bromelain. It can be destroyed by heating at 60°C for one hour as has been demonstrated by Klein.¹⁰

Enomoto *et al*¹¹ demonstrated that ethylmaleimide, a specific and irreversible inactivator of -SH enzymes, destroyed the ability of bromelain to prevent epinephrine-induced pulmonary edema. This treatment also inhibited the blood-pressure-lowering, cardiac-output-increasing and anti-inflammatory action of bromelain. Since the main protease fraction is known to have an essential -SH group, these investigators concluded that it must be responsible for the unique pharmacological properties of bromelain. However, Heinicke found that the protease purified by adsorption of IRC-50 did not produce the dramatic physiological responses that are characteristic of bromelain. This observation has been confirmed by other investigators. Furthermore, Katori and Shigei noted that the kinin-releasing action of bromelain was inhibited by soybean trypsin inhibitor. Since the main protease of bromelain is not influenced by soybean trypsin inhibitor, it is obvious that an enzyme other than the main protease is responsible for the kinin release. It is probably the enzyme which has been isolated by Houck. This physiologically active component of bromelain has been named escharase by Houck and Klein because of its ability to remove a burn eschar. A complete elucidation of the chemical and enzymatic properties of escharase is needed.

Oral bromelain has been demonstrated to produce effects in remote parts of the body. These observations indicate that escharase is producing a circulatory hormone with general systemic effects as proposed by Gerard. Many of these effects are similar to those reported for PGE₁ infusions. Bromelain and PGE₁ infusions do not produce exactly identical results; surprisingly, in some instances, the bromelain action appears to be more effective than the *in vivo*

results with PGE₁. Since PGE₁ has been shown to be over 90% destroyed by a single pass through the lungs, infusions are not considered to be a practical systemic treatment. Bradykinin is destroyed in the lungs even more rapidly than is PGE₁. However, some kinins are much more resistant to destruction than is bradykinin. A more stable kinin with the ability to stimulate local PGE₁ production would obviously have many practical advantages. In addition, biological prostaglandin production is not limited to a single component; several related compounds have short lives but important control functions.

The reported pharmacological effects of bromelain will be considered in relationship to the above proposed hypothesis in the balance of this review.

1. Stimulation of Muscle Contractions

It is well known in Hawaii that eating a lot of fresh pineapple may be followed by abdominal cramps and diarrhea. In a six-month bromelain feeding trial on dogs, conducted by Woodard Research Corporation, soft stools occurred frequently for the duration of the test in the dogs receiving 750 and 150 mg/kg/day. These observations indicate smooth muscle stimulation and similar responses have been reported for PGE₁.¹²

Direct evidence of intestinal muscle contractions induced by a bromelain component is shown in Figure 1. Heinicke¹³ prepared this fraction by adjusting a solution containing 4 mg bromelain per ml to pH 3.0 and heating rapidly to 85°C, neutralizing the excess acid and separating the clear solution from the coagulated precipitate. The heat-resistant bromelain fraction exhibits a delayed effect on muscle contractions as compared to PGE₁. This delay amounts to about eight minutes, in contrast to one minute for starting the contractions. The delay in the wash period is about two minutes, versus less than one minute for PGE₁. The delay probably represents the longer time for a large molecule to diffuse to the sight of the response combined with the time to build up the concentration of the active component in the stimulatory phase of the test.

This test gives a rough measure of the amount of PGE₁-like compound liberated by bromelain from rat intestine. Heinicke calculated it to be equivalent to 150-300 micrograms PGE₁ per gram of bromelain.

2. Smooth Muscle Relaxation

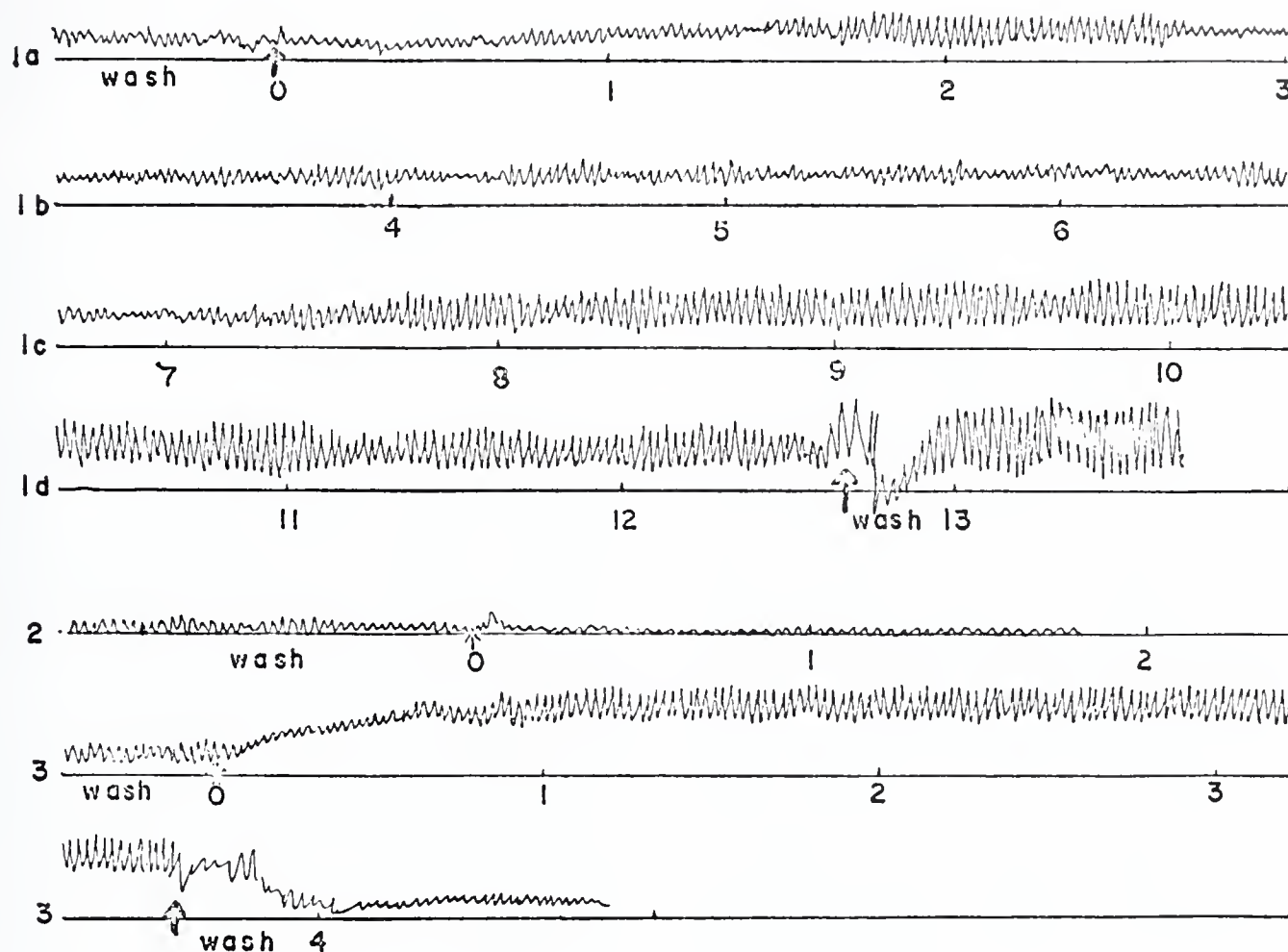
An example of muscle relaxation by bromelain is the effect on the contracted cervix in primary dysmenorrhea reported by Hunter *et al*.¹⁴ The rapid and dramatic relief of dysmenorrhea by bromelain (or papain) solutions was one of the first indications that these natural enzymes contain a physiologically potent factor. Failure of bromelain protease, purified by adsorption on IRC-50, to produce this muscle-relaxing result

FIG. 1.—Effect of various materials on the contraction and tension of a strip of rat intestine immersed in a balanced salt solution. The time is given in minutes.

Number 1 is a solution of the acid and heat resistant factor in bromelain. Note the delayed effect as compared to known PGE_1 . Note also the increased amplitude in the wash phase. This increase may be a result of additional oxygen in the wash water indicating that oxygen is required to produce the compound that is stimulating the muscle contractions.

Number 2 represents the effect of a purified bromelain preparation prepared so as to be deficient in the active factor. Note the lack of any effect.

Number 3 represents the action of 0.1 microgram/ml of PGE_1 . Note the quick action and the rapid wash out at the end of the test.



was the first indication that the pharmacologically important factor was not the main protease. The nature of the response was also an early indication that a hormone-like effect might be involved in this phenomenon.

Horton¹⁵ has found that there is a rise in both $\text{PGF}_{2\alpha}$ and PGE_2 in the endometrium during the normal human menstrual cycle. Lindner *et al*¹⁶ have shown that the symptoms of primary dysmenorrhea could be effectively alleviated by prostaglandin synthetase inhibitors. These results were due not only to synthesis inhibition but also to competition for prostaglandin binding sites on the uterus. These results indicate that the effectiveness of bromelain released PGE_1 -like compounds may be due to displacing $\text{PGF}_{2\alpha}$ from the uterine binding sites.

3. Inhibition of Blood Platelet Aggregation

Heinicke *et al*¹⁷ demonstrated *in vivo* the ability of bromelain to decrease the sensitivity of human blood platelets to aggregation by ADP. Each volunteer was given two Ananase 100 tablets (80 mg bromelain) and blood platelet samples taken before and two hours after ingestion were com-

pared. The results indicated that almost four times as much ADP was required after the Ananase treatment to induce aggregation. Numerous laboratory tests by Heinicke indicate similar results *in vitro*.

The great potency of PGE_1 in decreasing aggregation of blood platelets was first reported by Kloeze.¹⁸ An *in vivo* test in man with infusions of PGE_1 for thirty minutes did not show a measurable effect.¹⁹ An *in vivo* test with rats at a rate of 2 mg/kg did show significant inhibition of aggregation.²⁰ The significant test with Ananase 100 may show that bromelain is a better way of supplying a PGE_1 -like effect *in vivo*, or it may be due to selecting subjects with more sensitive platelets. The changes measured by Heinicke were greater for the subjects whose platelets were the most sensitive.

The inhibition of platelet aggregation by PGE_1 has been shown to be due to an increased level of cAMP.²¹ This result is caused by stimulation of adenylyl cyclase activity. CyclicAMP in platelets is also increased by phosphodiesterase inhibitors such as caffeine. The PGE_1 and caffeine effects are synergistic. An experiment in which the con-

centration of cAMP expressed as nano mols per milligram protein in platelets was increased from 1.6 to 2.2 by caffeine and to 5.4 by PGE₁ was increased to 24.4 by the combination of caffeine and PGE₁. Other agents which decrease platelet aggregation have been shown to increase cAMP levels and presumably the bromelain effect is through the same system.

The cardiovascular effects of PGE₁ are not limited to inhibition of platelet aggregation. Infusion of PGE₁ increases the heart rate and reduces the blood pressure. The reduced blood pressure is ascribed to peripheral vasodilation. An increase in heart rate and a decrease in blood pressure is also produced by PGE₂, PGA₁ and PGA₂. It is also noted when bromelain is injected into test animals.

Infusions of PGE₁ in man²² cause a reddening of the face and an oppressive feeling in the chest. A surface reddening has been noted in the intravenous infusion of bromelain into chickens.

The long range effects of bromelain on blood platelets have not been studied scientifically. However, one case in which 240 mg of bromelain were taken daily for four weeks resulted in platelets changing from a very sensitive type to normal requiring more than 100 times as much ADP to induce aggregation at the end of the test period. Blood pressure also changed from very high to normal. The technician testing the platelets noted at the end of the first week that he was examining a mixture of two distinctly different types of platelets, part normal and the rest distinctly abnormal in appearance. It would appear that bromelain should be tested as a long term maintenance treatment for individuals with enhanced platelet aggregation rates.

4. Enhanced Antibiotic Absorption

There are many ways to demonstrate the effect of bromelain on tissue permeability. The most dramatic is to inject it intravenously into a chicken. With a sufficiently large dose, the chicken will be bleeding from its wing tips in a matter of seconds. The company using enzymes intravenously for tenderizing meat had to develop a method of pretreating the enzyme solution with a mild oxidizing agent to destroy this factor.²³ Both bromelain and papain contain animal reaction factor, but bromelain is a much richer source. The animal reaction factor is probably escharase.

A more useful demonstration of increased permeability is the effect of bromelain on antibiotic absorption. A typical example is the three-fold increase of tetracycline in serum after the oral ingestion of two tablets containing 250 mg tetracycline hydrochloride and 40 mg bromelain in the enteric coated core as compared to two tablets containing 250 mg tetracycline hydrochloride alone. This double blind test was reported by Renzini and Varengo.²⁴ Antibiotic

potentiation is one of the main uses for bromelain in several foreign countries, but has not yet been approved in the United States.

Other examples of increased antibiotic levels associated with ingestion of bromelain have been reported by Giller²⁵ and by Bodi.²⁶ Giller showed an increase in penicillin in the cerebrospinal fluid of rabbits treated at a level of 25 mg/kg animal weight. Levels of 5 mg/kg or less did not show a significant change. Bodi showed an increase in tetracycline in cantharides blisters in a double blind test on human subjects.

5. Cancer Prevention and Remission

Sheppard²⁷ has pointed out that three observations indicate the importance of cAMP in the control of cell growth. These observations are that cAMP levels are lower in transformed cells than normal cells, agents which increase cellular cAMP levels suppress growth and agents which decrease cellular cAMP levels stimulate growth.

Otten *et al*²⁸ have demonstrated that transformation of chicken embryo fibroblasts by a temperature sensitive mutant of Rous sarcoma virus is partially inhibited by phosphodiesterase inhibitors, such as theophylline, and completely blocked by a combination of phosphodiesterase inhibitor and dibutyryl cAMP, which maintain the cAMP levels in the normal range.

Sheppard²⁷ has reported that PGE₁ will restore cAMP levels to normal for limited periods of time in certain transformed cells. As long as the cAMP levels remain in the normal range these cells exhibit the characteristics of normal cells.

Pastan,²⁹ reviewing the role of cAMP in cancer research, pointed out that only embryo cells and those derived from connective tissue exhibit a morphological reversal to cAMP. In spite of these limitations, the active principal in bromelain appears to offer great promise for a new approach to cancer therapy.

Braun and Shinozawa³⁰ have shown that phosphodiesterase activity is excessively high in tumor cells. This observation indicates that a phosphodiesterase inhibitor should be combined with an adenyl cyclase activator to secure maximum increase in cAMP and thus inhibit transformation or revert transformed cells to normal characteristics.

The hypothesis presented in this paper would explain the effects of bromelain as being due to the release of a circulating hormone (PGE₁-like action) which stimulates increased levels of cAMP in cells and thus inhibits their tendency to be transformed by carcinogens. In the case of cells which have already been transformed, it would temporarily restore their properties to the range of normal cells but would not permanently reverse the transformation. It would be necessary, therefore, to continue the treatment until the transformed cells have been destroyed and replaced by normal body regenerative processes.

This implies a long period of treatment; Gerard found this to be so.

Most of the animal test systems used to evaluate anti-mitotic activity are not suitable for testing bromelain. It appears that the test animals are overwhelmed by the massive inoculations and the stimulation of their defense systems is not sufficient to cope with the invasion. However, in slow developing tests the value of bromelain is being demonstrated. Goldstein *et al.*³¹ have shown increased resistance to skin cancer produced by ultra violet irradiation. Other slow developing systems can also be used. However, this limitation means that long test periods are required.

In Europe bromelain has been used in human cancer cases. Nieper³² reported in November 1975 that he had treated more than 250 human cases. Nieper's regimen includes a variety of chemotherapeutic and nutritional factors in addition to bromelain.

6. Burn Debridement

Early attempts to remove a burn eschar by various enzymes were based on the ability of the enzymes to digest the eschar. This approach has not been satisfactory and the commercial products that were on the market have been withdrawn. Klein¹⁰ found that bromelain will remove an eschar by what he calls the "dissecting plane" approach. This means that bromelain separates the eschar exactly at the interface with the living tissue thus achieving chemically what the surgeon is doing with his knife. Klein's hypothesis is that the escharase in bromelain activates collagenase. The activated collagenase from the living tissue attacks the denatured collagen in the eschar and thus produces a cleavage exactly at the demarcation between the living and dead tissues. Klein's work has been confirmed by Levenson's group.^{33,34}

Klein has found that purified escharase is faster and more dependable than regular bromelain. Since bromelain protease has a potent kininase activity, it would be expected to destroy the kinin produced by escharase. The kininase activity of bromelain could account for the poorer results with the total enzyme mixture as compared to purified escharase. The rate of penetration under the eschar was determined to be about 20 cm in 30 minutes.

One of the interesting results of the Klein technique is that the bromelain or escharase treated burns heal without the development of scar tissue. There do not appear to be any references in the literature that would suggest that PGE₁ is involved in producing the dissecting plane phenomena on a burn eschar. There are references which support the favorable effect of PGE₁ on epithelial growth.³⁵

7. Prevention of Epinephrine-Induced Pulmonary Edema

The ability of bromelain to inhibit epineph-

rine-induced pulmonary edema was first reported by Mosse *et al.*³⁶ Epinephrine at a dose of 1 mg/kg in mice usually resulted in deaths to 75-80% of the test animals. Bromelain injected 30 minutes prior to the epinephrine resulted in a significant reduction of deaths and a marked decrease in weight of the lungs of the autopsied animals.

The protective effect of bromelain has been studied in Japan by Shigei and his co-workers. After showing first that bromelain was effective and that papain and ficin were relatively ineffective, they purified bromelain¹¹ and reacted it with ethyl maleimide, a specific irreversible -SH inhibitor. The ethyl maleimide-treated enzyme no longer protected against epinephrine-induced pulmonary edema. Shigei was surprised that papain and ficin did not show much epinephrine-inhibiting action, since they are also sulfhydryl proteases. It is apparent that escharase must be very closely bound to the main protease as it carried through the purification step and also that escharase must have an -SH group.

In another experiment on rabbits, Mineshita and Shigei³⁷ found that it was necessary to inject the bromelain immediately after the epinephrine injection to obtain maximum inhibition in rabbits. The rabbits were not protected by injections ten minutes before the epinephrine, whereas rats were adequately protected by injections at that time.

8. Anti-Inflammatory Action

Inflammation is a complex process still not completely understood. The role of prostaglandins in inflammation is controversial, but there is no doubt that they have important functions in the body's response to injury and in recovery from it. Recent discoveries have helped to clarify some aspects of inflammation and further research should eventually lead to a complete understanding. Before explaining how bromelain may play a part in recovery from inflammation, the role of prostaglandins in the body's response to traumatic injury may be considered briefly.

The prostaglandin detected first in an injury area is PGE₂.³⁸ However, the endoperoxide intermediates, PGG₂ and PGH₂,³⁹ are formed before reaching the more stable PGE₂ stage. The discovery that PGG₂ and PGH₂ are very potent stimulators of blood platelet aggregation indicates their vital role in stopping the loss of blood from an injured area. Recently⁴⁰ it was reported that PGG₂ and PGH₂ do not directly cause aggregation but that they are converted in part to thromboxane A₂ which is responsible for the platelet aggregation. Thromboxane A₂ has a half life of only 34 seconds, and has been shown to be the long sought rabbit aorta contracting substance (RCS).

PGE₂ has several vital functions in the body's

response to injury. It is a potent activator of the pain receptors to make them responsive to chemical and mechanical stimuli. This is obviously an important function to prevent excessive movement in the injured area. PGE₂ also may induce fever to provide conditions that are more favorable for combating and destroying bacterial or viral invasions. PGE₁ and PGE₂ will also produce headaches.

PGE₂ increases tissue permeability, which results in fluid flowing into the affected area. This swelling is accompanied by and is vital for the movement of phagocytic cells into the injured area. These cells, such as the PMN leucocytes, help to destroy bacteria and to consume tissue debris. The PMN cells liberate proteolytic and carbohydrate-splitting enzymes which play a role in the cleanup action. However, these released lysosomal enzymes are inflammatory and may be responsible for some types of chronic inflammation, if their release is continued too long.

Within three hours after the PMN cells have been found in the injured area, PGE₁ is detected in measurable amounts. Both PGE₁ and PGE₂ have been shown to be chemotactic for PMN cells. This means that these two prostaglandins will induce movement of the PMN cells through membranes in order to reach areas where there are appreciable concentrations of PGE₁ or PGE₂. The involvement of prostaglandins in inducing tissue permeability and accompanying swelling, fever and headaches is shown since prostaglandin synthetase inhibitors (e.g., aspirin) reduce all of these symptoms. They also reduce the number of PMN cells in the injury area.

The effect of PGE₁ in edema has been shown by Glenn *et al*⁴¹ to be dependent on concentration. It has a maximum effect at 1 microgram per rat paw. At 80 micrograms per rat paw it does not produce any edema, although it still shows erythema.

As the PGE₁ level increases, it tends to inhibit the release of lysosomal enzymes from PMN cells.⁴² This change does not decrease the ability of the PMN's to consume bacteria and debris.

It has been shown that the PGE₁ is being produced by the PMN cells. It appears that the PGE₁ properties are such that at low concentrations they tend to foster the changes that bring the defensive agents to the injury site; as the healing process proceeds, the higher levels tend to inhibit the inflammatory actions which were vital for mobilizing the body's defenses.

There are extensive clinical reports on the anti-inflammatory use of bromelain, papain, trypsin and chymotrypsin. However, the F.D.A.⁴³ claims that these tests do not prove that the products are effective. The lack of an adequate explanation for the anti-inflammatory action of the enzymatic products has undoubtedly contributed to the reluctance to accept the reported clinical results. The hypothesis is that there are at least three ways in which bromelain

may influence anti-inflammatory responses: 1) depletion of kininogen, 2) the activation of plasmin and 3) stimulation of production of the PGE₁-like compounds.

The depletion of kininogen I has been shown to inhibit edema.⁴⁴ Since Katori and Shigei have shown that bromelain will deplete kininogen I completely, it is obvious that this response could account for the ability of bromelain to decrease swelling.

Martin's group² has shown that oral bromelain will produce a two- to five-fold increase in serum plasmin concentration of rabbits. This result is probably due to activation of the plasmin by the kinin produced from kininogen I. It has been demonstrated that the kinin, eledoisin, will greatly increase the fibrinolytic activity of blood in man. The ability of bromelain to increase fibrinolysis could be an important element in speeding recovery from injury.

The fact that PGE₁ production is associated with the presence of PMN cells indicates that this type of prostaglandin may be important in body repair processes. It has been shown that PGE₁ is responsible for decreased release of lysosomal enzymes. The ability of PGE₁ to decrease platelet aggregation and thus help to prevent blood clot formation would also appear to be important.

It has been common to consider together all of the enzymes that act as anti-inflammatory agents. However, it is apparent that there are some very important fundamental differences. Both trypsin and bromelain will deplete kininogen and thus could influence edema in the same way, but their actions in prostaglandin production are quite different. Whereas the PGE₂ related compounds released by trypsin-produced bradykinin will cause platelet aggregation, bromelain will produce compounds that inhibit aggregation.

There is a simple test that anyone can make to demonstrate the effectiveness of bromelain as an anti-inflammatory. If a person has exercised enough to produce extensive muscle soreness, a single massive dose of bromelain will relieve the soreness in a short time. The time required is comparable to that for a response to aspirin.

9. Ulcer Prevention

Bromelain has been reported to heal ulcers.^{45,46} PGE₁ has been reported to prevent ulcers in experimental animals.^{47,48} Its effectiveness is apparently due to reduced gastric secretion of acid. The curative effect of bromelain could be due to its PGE₁-like activity.

Another possible reason for a positive effect on gastric ulcers is covered in a report by Kim.⁴⁹ In an extensive study of the bromelain effect on the gastric mucosa, Kim found that bromelain increased the uptake of radioactive sulfur by 50% and of tritiated glucose amine by 30 to 90%. This increased uptake of sulfur and glucose amine would indicate that the protective lining of the gastric system might be repaired more readily

under the influence of bromelain. It would appear that the effect of bromelain on the gastric mucosa might be a valuable adjunct for long-range recovery, combined with the use of acid-neutralizing agents.

10. Sinusitis Relief

Bromelain taken as an adjunctive therapy has been shown to speed recovery from sinusitis.⁵⁰⁻⁵⁵ PGE₁ has been shown to increase the air passage openings in the nose when infused or applied as an aerosol spray. Bromelain has usually been used in an oral tablet, but an unpublished report on its use in an aerosol spray gave results similar to those reported for PGE₁. Treatment of sinusitis appears to be another example with similar results for bromelain and PGE₁.

11. Shortening of Labor

Youseff⁵⁶ reported that bromelain was without effect in the induction of labor, but that it significantly shortened the time in labor. The treatment was especially effective for primiparas with abnormal rigidity of the cervix.

The bromelain action during labor described by Youseff appears to be similar to the effects on dysmenorrhea covered in an earlier section. Since the strong uterine contractions in labor have been shown to be due to PGF_{2α}, the relaxation by bromelain douche of the lower uterine section probably represents another example of the PGE₁-like compounds competing with PGF_{2α} for receptor sites on the uterine wall.

12. Enhanced Excretion of Fat

Kugener *et al*⁵⁷ showed a marked increase in

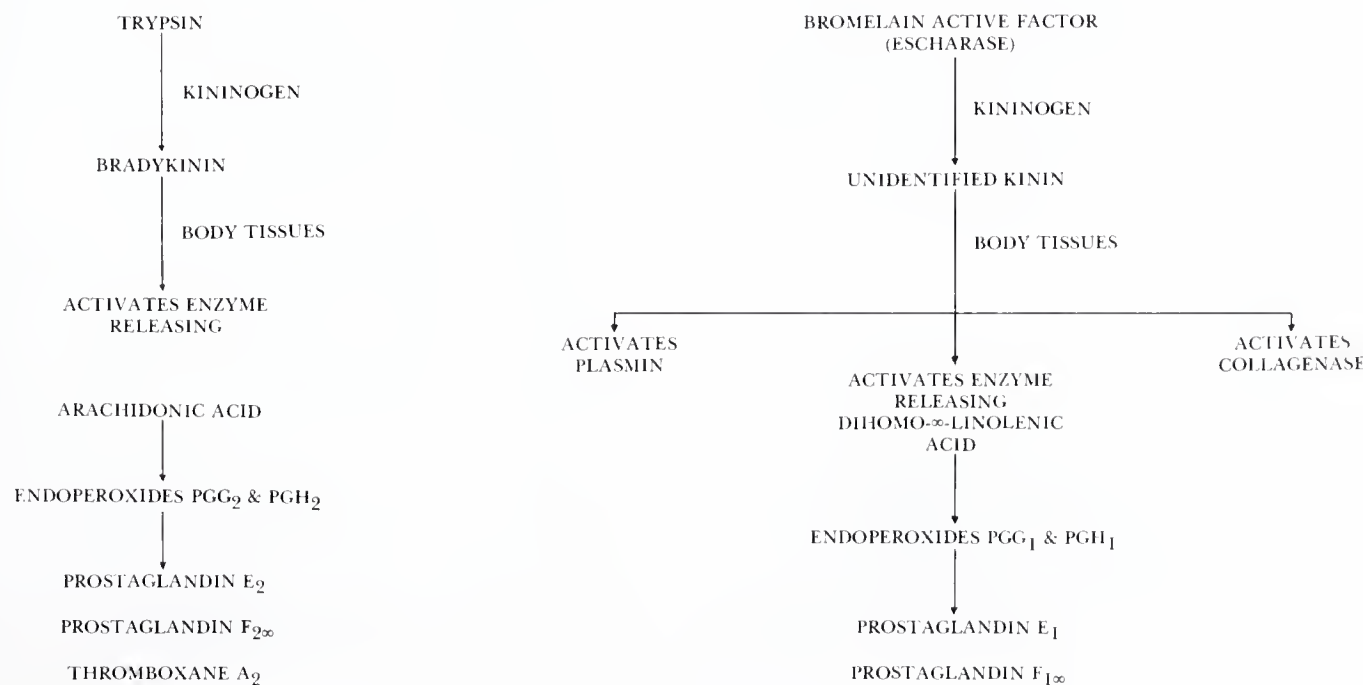
fat excretion in patients with exocrine pancreatic insufficiencies when consuming one to four grams of bromelain per day. They attributed this result either to disturbances in lipase action and/or to disturbances of intestinal absorption. There was a significant 26% increase in stool weight which is consistent with the laxative effect of bromelain. It also appears that lipase production was being interfered with since their patients did not have the increased fat excretion response when a sufficient amount of pancreatin was supplied with the bromelain.

13. Appetite Inhibition

Six month feeding studies by Woodard Research Corporation on dogs and rats at rates of 750, 150 and 30 mg/kg/day showed that there was no indication of toxicity or other adverse effects on the animals. In an even more drastic test, Kim used higher levels in the diets of rats. He found that above 2,000 mg/kg/day, the rats essentially stopped eating and drinking and starved to death. Even in these animals he could find no evidence of toxicity. This effect has been confirmed in independent tests on chickens and mice. At some level these animals would also stop eating and would starve to death. The level required is variable depending on the type of animal. In the test with chickens, it was determined that heating the bromelain to destroy all enzyme action eliminated the appetite destroying effect.

The fact that 1 microgram/min. of PGE₁ will completely inhibit gastric secretion induced by food, histamine, pentagastrin or d-deoxyglucose would indicate that a PGE₁-like compound might have a strongly depressing effect on appetite.

FIG. 2—Comparison of Proven Action of Trypsin With Hypothesized Action of Bromelain



These tests appear to establish that bromelain is quite safe to use at the levels which have been shown to produce the effects covered in this review. Even in the treatment of cancer the highest level used was about 40 mg/kg/day.

Discussion

The important points in the hypothesis to explain the action of bromelain are listed in Figure 2 and compared with the reported action of trypsin. The analogy between bromelain and trypsin is good but not perfect. There is a significant difference in the first step. Trypsin acts directly on kininogen to produce bradykinin. Bromelain does not produce a kinin directly, but activates kallikrein which in turn acts on kininogen to produce a kinin.

Since bromelain produces a combination of responses which are known effects of PGE₁, it is highly probable that it is stimulating PGE₁ production in the body. The most important of these responses are muscle contractions, muscle relaxation, increased tissue permeability, inhibition of platelet aggregation, increased heart rate, lowered blood pressure, increased cardiac output and inhibition of epinephrine action.

There are two important responses to bromelain which do not appear to involve prostaglan-

din synthesis. One is the activation of plasmin and the other the activation of collagenase.

There appears to be a close relationship between kininogen levels and prostaglandin production in the body. Wieggershausen *et al*⁵⁸ showed that kininogen levels during gestation increased three fold and then dropped sharply during normal birth but did not decrease sharply in 14 cases where the deliveries were by Caesarean section. The drop during normal birth must be due to the production of PGE₂ and PGF₂₀₀. It takes several hours for kininogen levels to return to normal after they have been depleted.

The stimulation of production of natural prostaglandins by the normal body systems would appear to be a more desirable therapy than using preformed prostaglandins or prostaglandin analogues. The unstable intermediates in prostaglandin synthesis have been shown to have important control functions.⁵⁹ Analogues which the body has difficulty in destroying may lead to undesirable side effects.

Some Indian tribes living in America at the time of Columbus were using pineapple as a medicinal.⁶⁰ It now appears that medical science has reached the point where it will soon have an explanation in terms of classical medical knowledge for the therapeutic properties of the pineapple plant and fruit.

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Capital Fund Advance Plan which was adopted by the House of Delegates to enable HMA to purchase its own quarters, was due December 31, 1976. The House of Delegates adopted this Plan as a mandatory loan program for all existing and new members of the HMA and, as such, participation in this Plan is required for continued membership. The bylaws of HMA call for members that have not fulfilled financial obligations to the HMA to be declared delinquent by March 31, 1977, and, unfortunately, to be dropped from the HMA membership rolls. If you have not yet selected an option to fulfill the obligation to the Plan, or if you are still not clear as to the details and purposes of the Plan, please call the HMA office, or any of the officers of YOUR association.

A Symposium on Patient Compliance—An Interprofessional Challenge, is scheduled for all-day, Sunday, March 27, 1977, at the Ilikai Hotel. Jointly sponsored by the HMA, Nurses Association, and the Pharmacy Association. Participants will include Barbara S. Hulka, M.D., Univ. of North Carolina, Lida Chase, U of H School of Nursing, Daniel A. Hussar, Dean of Philadelphia College of Pharmacy and Science. Lederle Laboratories is graciously supporting this symposium, including luncheon and reception following the session. Spouses are invited and welcome. No registration fee but pre-registration needed, and registration forms and programs will be sent shortly to all members.

Recent Gallup Poll shows that no organization rates higher than the AMA in *public credibility*. On a ten-point scale, AMA ranked 6.8. Average for professional associations was 6.5, for government agencies 5.7, for labor unions 5.4, and for trade associations 5.1. Another Gallup poll

showed that 71% of the public said it had a great deal or a fair amount of confidence in physician organizations to propose fair and workable health programs. Only 49% of the public gave these ratings to federal health officials.

The Often Repeated Assertion that medical expenses are the number one cause of personal bankruptcies in the U.S. cannot be authenticated by the Congressional Budget Office, despite exhaustive research, according to Washington reporter William Hines.

Islanders Baseball Team is asking for support through the Mayor's Islanders Fund. Five Dollar Pass Tickets, good for 5 games, including parking. If interested, contact the HMA office for more information.

JCAH has announced that two long-term facilities, Nuuanu Hale and Wahiawa General Hospital-SNF, have recently been accredited by the JCAH.

1977 American Medical Society of Vienna Seminar Congresses have been announced. TWA, who has sponsored these conferences the past two years, wishes all physicians to be aware of the 1977 seminars which are available throughout 1977. Different aspects of medicine are presented, including Acupuncture, Anesthesiology, Dermatology and Syphiology, Internal Medicine, Neurology and Psychiatry, Ob-Gyn, Ophthalmology, Orthopedic and Traumatic Surgery, Otorhinolaryngology, and Pathology. Seminars take place at the University of Vienna Medical School. For more information, call HMA.

Family Planning Institute, a patient-oriented medical facility specializing in reproductive health, has opened in Aiea. One of its major objectives is to treat patients as individually as possible and, in order to do so, has departed from some traditional practices, such as controlling patient case loads to provide more time with patients. Medical services are provided under the supervision of a medical director with a physician and nurse/counselor on call 24 hours a day. Medical services include breast cancer detection, diaphragm fitting, gonorrhea cultures and treatment, IUD insertions, Pap Tests, pregnancy testing, pregnancy termination, and vasectomies. Patients can have either individual or group counseling for all medical services. The medical director is Laurence A. Reich, M.D.

Nurses Should Be Independent Practitioners, answerable only to their patients, and subject to the same accountability as physicians, including malpractice liability. Luther P. Christman,

Ph.D., Dean of the College of Nursing, Rush-Presbyterian-St. Luke's Medical Center, Chicago, expresses this opinion in the first issue of a new journal, *Nursing Administration Quarterly*, and calls this new concept "autonomous nursing."

A Denver-Based Firm recently indicted for stealing medical records and selling them to life insurance companies. Alfred Freedman, M.D., head of the recently formed National Commission on Confidentiality of Health Records feels that this incident is only the tip of a nationwide iceberg. This Denver-based firm has offices in 15 cities around the country and allegedly used a variety of fraudulent methods, such as impersonating physicians, to obtain health and medical records. This firm is also under investigation by the FBI and the IRS. Dr. Freedman said that with the advent of some form of national health insurance, assaults on privacy and the confidentiality of doctor-patient relationships would increase.



Illness is no respecter of time.

Two days in the hospital for an I & D of a pilonidal abscess that required general anesthesia. The bill (hospital only): \$720.00—nearly three fourths of a thousand dollars. Incredible, you say? Doctor, you probably have no idea of the dollar costs of what *you* order!

Sure, and H.M.S.A. paid 90% of the bill. But, 10% of \$100 is only \$10, which is relatively easy on the patient's pocketbook. In our case above, the 10% amounts to a whopping \$72—seven times ten dollars. And, what if H.M.S.A. does

cover 90% of the bill? What H.M.S.A. pays is just one iota of what it pays out in "benefits" for the year to those of its several hundred thousand subscribers who happen to get sick or injured during the year. Benefits paid out must be matched by premium dollars paid in, and then some—to cover administrative costs, reserves, etc.

If this is any kind of a representative example of modern hospital charges, it becomes crystal clear to all who would investigate why medical care costs have sky-rocketed. The in-hospital component is primarily responsible for the escalation. Not that the \$720/2-day bill is a rip-off! Far from it. The seemingly exorbitant charge may not quite cover the actual cost to the hospital for the care and service to that patient, indeed.

The solution surely must lie in the realm of Organized Medicine working with the hospitals and their associations in order to devise ways of reducing these costs. The costs of hospitalization may soon be, if they aren't already, working against optimum medical care of the patient who truly needs intensive care.

There must surely be many ways in which savings can be obtained, but perhaps the first item on the list should be the elimination of the "weekend."

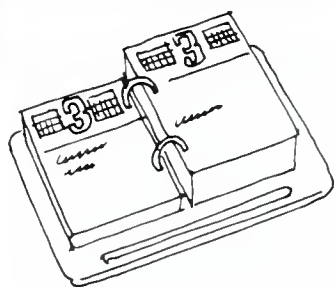
"Doc, I waited until today, Monday, with this belly-ache," says the bent-over, pale and diaphoretic patient, "because I didn't want to disturb your Sunday." (Bless him, the patient was being too considerate of his friend, the doctor!) The fault lies with our system. The nasty appendix didn't know enough to conform to Man's time schedule and calendar. It ruptured itself on our Sabbath Day, instead of properly on a working day.

"Mrs. Jones, you need to be in a hospital," says the doctor to his patient, "but you know how it is on weekends: Only dire emergencies get taken care of. Let's admit you on Monday." The patient's work/time loss was extended. The busy doctor should have used the weekend to work-up the admission instead of cramming the extra duty into office hours and thereby discomfiting other sick people.

The first example is a bit of facetiousness. The second points directly at costs. In this day and age of a \$150 to \$300 hospital day, it is truly a "rip-off" of both the patient and the third party that protects him fiscally, to have hospital service be largely paralyzed by a Saturday and/or Sunday.

This is not necessarily to speak against the Sabbath as it affects nearly all walks of life. Our plea is that since illness and injury hold no respect for Man's time-frames, the service institutions that deal with the victims of such apocalypses should no longer indulge in practices that have become luxuries that the common people can no longer afford.

J.I.F.R.



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Tuesdays, 10:00-11:30 a.m. at Queen's or St. Francis. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Mabel Smyth Bldg. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 521-5064.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

(Contact CME Dept. for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
- Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
- Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
- Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room

3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

St. Francis Hospital

1. Medical Grand Rounds, Tuesday (4th & 5th) 12:30-1:30 p.m. Sull. IV Classroom
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
7. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu

Type: I, 1 hr/day, 1 day/mo from 12 mos

Fee: None Methods: AV, O, Pan

Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

Type: I, 1 hr/day, 1 day/mo for 8 mos

Fee: None Methods: AV, Clin C, O, Pan, R

Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

Jan. 27- "Interdisciplinary Health Team Development"
March 31, —Manoa Campus, Schl. of Med. Thurs.
1977 6-9 p.m. 8 sessions, 24 hrs. Cat. 1. Contact:

John Watson, M.D. 948-8895 or Mrs. Bermosk 948-7053.

- Mar. 3
April 7
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June 16
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- "Fundamentals of Echocardiography"—Dr. V.E.M. Friedewald, Jr.; 12:30-1:30 p.m. HI Heart Assoc & Queen's Med. Cntr. Hono. Med. Group-Queen's Med. Cntr. Nalani 1 Conf. Rm. Contact: Ellie Morris, Cardiac Lab. Queen's ph. 538-9011 Ext. 535.
- Visiting Professor of Oncology, American Cancer Society, HI Div., Inc., 200 N. Vineyard Blvd. Hono. 96817. Ph. (808) 531-1662 for further info.
- "Diagnosis & Treatment of Non-Invasive Bladder Neoplasms"—Tuesday-12:30 p.m. Wahiawa Hsp.-Speaker: James H. DeWeerd, M.D. 1 hr. credit-Contact: Norberto Baysa, M.D. Wahiawa Hsp. CME Department.
- "Diagnosis of the Renal Mass Lesion"—Sat. 7:30 a.m. Kaiser Pac. Aud.-Kaiser Hsp. -Speaker: James H. DeWeerd, M.D. 1 hr. Cat. 1-(Contact CME Dept. for further info)
- Oncology Clinics-Unv. of Minn. Med. Schl. Box 293, Mayo Mem. Bldg. Minn. 55455. Held at Hyatt Regency Hotel, Honolulu. Fee \$250.
- "Trauma," "Endocrine Diseases," "Exercise," and "Antibiotic Selection." Kansas City SW Clin. Soc. 2220 Holmes St. Kansas City, Mo. 64108. Co-Sponsor: Unv. of Mo.-Kansas City Schl. of Med. Held at Maui Surf Hotel, Maui, HI Fee \$100.
- "Care of the Critically Injured"—Wahiawa Hsp. Tues.-12:30 p.m.-Speaker: Manuel A. Abundo, Jr., M.D. 1 hr. cred. Contact: Norberto Baysa, Wahiawa CME Dept.
- Sports Med. for the Primary Phys.-Unv. of HI Schl. of Med. 1969 East-West Rd., Hono., HI 96822. Held at Princess Kaiulani Hotel, Hono. Contact: Harold Brown, P.O. Box 22670, Hono. 96822. Fee \$200.
- "Basic & Advanced Cardiac Life Support Cert. Courses for Phys. Staffing Emergency Rooms" Am. Heart Assoc-HMA Emergency Med. Serv. Program & ACEP-Hawaii. St Francis Hsp., Ward 2B-Ed. Auf. 2230 Liliha St. Hono. 3 days-22 hrs. Cat. 1 AMA: AAFP-24 hrs. & ACEP Cat. 1-22 hrs. Contact: J.K. Sims, M.D. HMA/EMS: 1301 Punchbowl-Hono. 538-9011 ext. 471.
- "Hormone Receptor Assay in the Management of Breast Cancer"—Kaiser Pac. Aud.-Kaiser Hsp.-Speaker: Philip G. Hoffman, Jr., M.D. 1 hr. Cat. 1 (Contact CME Dept. for further info)
- Diving Med.-Undersea Med. Soc. c/o Professor E. Beckman, Unv. of HI Conf. Cntr. 1960 East-West Rd., Hono., 96822. Held at King Kamehameha Hotel, Kailua Kona, HI. Fee \$250.
- "Anemias in Childhood"—Wahiawa Hsp. Tues. 12:30 p.m.-Speaker: Robert Wilkinson, M.D. 1 hr. cred. Contact: Norberto Baysa, CME Dept. Wahiawa Hsp.
- "Management of Acute Cranial Cerebral Trauma"—Kaiser Pac. Aud.-Kaiser Hsp.-7:30 a.m. Sat. Speaker: Joel Feigenbaum, M.D. 1 hr. Cat. 1 (Contact CME Dept. for further info)
- "Coronary Artery Bypass"—Kaiser Pac. Aud.-Kaiser Hsp. Sat. 7:30 a.m. Speakers: Drs. Eugene Magnier, Masahiro Mori, Richard

Manniya. 1 hr. Cat. 1 (Contact CME Dept. for further info)

- Mar. 29,
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Apr. 2,
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Apr. 4-9,
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Apr. 9,
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Apr. 16-23,
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Apr. 17-30,
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- "Radiology of the Biliary System" Tues. 12:30 p.m.-Wahiawa Hsp. 1 hr. cred. Cat. 1-Speaker: Norman Ikemoto, M.D. Contact Norberto Baysa, M.D., CME Dept. Wahiawa Hsp. for further info.
- "Prospective Medicine"—Sat. 7:30 a.m.-Kaiser Pac. Aud.-Kaiser Hsp. Speaker: Frederick Dodge, M.D. 1 hr. Cat. 1 (Contact CME Dept. for further info)
- Adolescent Medicine-Unv. of HI Schl. of Med., Dept. of Pediatrics, 226 N. Kuakini St., Hono., 96817. Held at 1319 Punahou St. Hono., 96814. Fee \$40.
- "Asthma-Planning for Diag., Treatment & Patient Education"—Kaiser Hsp. Kaiser Pac. Aud. Sat. 7:30 a.m. Speaker: Alexander Roth, M.D. 1 hr. Cat. 1 (Contact CME Dept. for further info)
- Emergency Medicine-Unv. of So. Calif. Schl. of Med. 2025 Zonal Ave. Los Ang. 90033. Held at Kona Surf Hotel, Kona, HI. Gail Anderson, M.D. Prof. of Emergency Med.
- Visiting Professor of Oncology, Am. Cancer Soc.-HI Div. Inc. 200 N. Vineyard Blvd., Honolulu 96817. 10 days 40 hrs. No fee. Ph. (808) 531-1662 for further info.

continued next page

*And it's a painful moment,
a lonely moment. In spite of
your grief, arrangements
must be made, details must
be taken care of.*

*At Borthwick Mortuary,
we're available at any time
to talk with you calmly,
openly, and sympathetically.
Since 1916, Honolulu
families have turned to us
at that moment.*

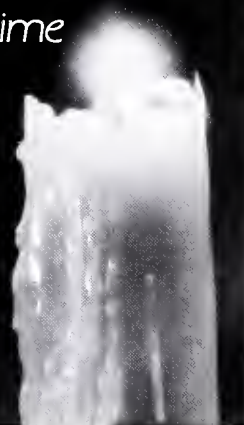
*We offer a wide choice of
facilities and services to
make arrangements that suit
your individual needs
and desires.*

In time of need, please call.

There comes a time



*Borthwick
Mortuary*
1330 Maunakea St.
Phone: 531-3566



Apr. 23 to June 1, 1977 Pediatric Workshop-Univ. Southern Calif. Schl. of Med. 2025 Zonal Ave. Los Ang. 90033. Held at Maui Surf Htl. Maui, HI. Faculty Coordinators: Drs. Geo. N. Donnell & Paul F. Wehrle.

Apr. 30, June 7, 1977 Management of the Surgical Patient. Stanford Univ. Schl. of Med. Stanford, CA 94305. Held at Mauna Kea Beach Htl. Kamuela 96743. 7 days 27 hrs. Fee \$275.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1976 Supplement to JAMA or call the HMA Office.



Friday, October 1, 1976, 5:30 p.m.
320 Ward Avenue

CALL TO ORDER

The meeting was called to order by President William W. L. Dang. Also present were Drs. Calvin C. J. Sia, R. Varian Sloan, Grover H. Batten, Herbert Y. H. Chinn, George Goto, John Kim, Sakae Uehara, Peter Kim, Douglas Bell II, Thatcher Magoun, William Moore, and Roy Kuboyama.

MINUTES

The minutes of the September 10, 1976, meeting were approved as circulated.

REPORTS OF THE COMMITTEE AND COMMISSIONS

A. Communicable Disease Committee: At the October 1 meeting of the Communicable Disease Committee, it was recommended that the following categories be listed as the high risk group with regard to immunizations for swine flu: persons 65 years of age and over; persons with chronic bronchopulmonary disease, such as asthma and cystic fibrosis; heart disease; chronic renal disease; diabetes and other chronic metabolic diseases; chronic neuromuscular disorders; and malignancies and immunodeficient states. The dosage levels for the high risk group with bivalent vaccine was also recommended as follows:

3-18 years	2 dosages (4 weeks apart) split vaccine
19-25	1 dosage whole virus
26-64	1 dosage whole or split
65 and over	1 dosage whole or split

ACTION:

It was voted to approve the recommendations of the Communicable Disease Committee.

B. EMS: The present three-year program is up in July 1977 and there is need for HMA action: (1) submit another grant for a statewide program or (2) develop substitute funding for a training program by the HMA. It is recommended that the staff begin to explore these alternatives and possible sources of funding for the program.

ACTION:

It was voted to approve the exploration of various alternatives for extension of the EMS program.

OTHER BUSINESS

A. Senior Management Conference: It was recommended that Mr. Won be registered for a Senior Management Conference to be held on Maui from November 10-13. The registration fee is \$550.

ACTION:

It was moved, seconded, and passed that Mr. Jon Won be registered for the management conference.

REPORT OF THE TREASURER

A. August 1976 Financial Statement: The August 1976 financial statement was reviewed in detail.

ACTION:

It was voted to accept the August 1976 financial statement subject to audit.

B. 1977 Proposed Budget: The proposed budget for 1977 was reviewed. The treasurer noted each item in the proposed budget and pointed out that there were several significant changes: (1) Annual meeting income is projected to increase as the AMA Regional Meeting will be held in conjunction with HMA's annual meeting in 1977. (2) Salary expense is increased due to new accounting methods and deletion of the Common Fund, the proposed addition of one new position, and some salary increases. (3) Rent has been deleted from the budget since moving from the Mabel Smyth Building. (4) Committee expenses were expected to increase with printing costs for the new RVS, the TelMed operation, printing of an annual roster, etc. (5) It is recommended that the Council Contingency fund be increased to allow for malpractice legal fees which could be offset by an assessment if necessary. The treasurer also reported that funds had been transferred to the reserve account by the Finance Committee. He also noted that while the Finance Committee agreed in principle that incremental raises in dues are warranted to keep up with increases in the cost of living, the committee did not agree on recommending a dues increase for 1977.

ACTION:

It was moved, seconded and passed to recommend to the House of Delegates that the proposed budget as submitted by the Finance Committee be approved.

C. Hawaii Medical Library: A letter was received from the Hawaii Medical Library requesting HMA to consider a contribution of \$100 from each member of the Association to the Library.

ACTION:

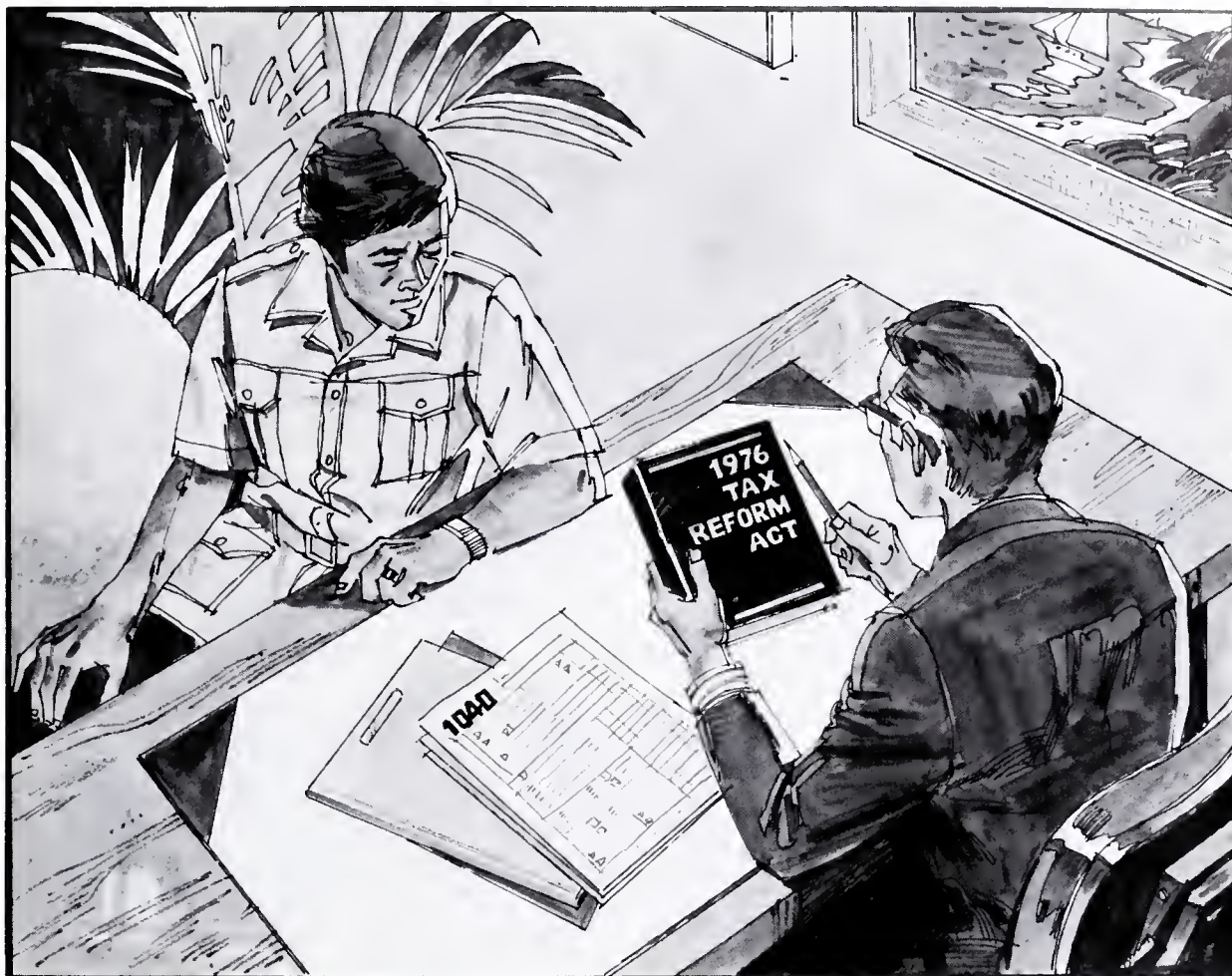
It was moved, seconded and passed to present this recommendation to the House of Delegates.

ADJOURNMENT

The meeting adjourned at 9:00 p.m.

R. VARIAN SLOAN, M. D.
Secretary

The tax laws have changed.



Should your financial plans change, too?

Just last year, a tax reform act was signed into law. It changes the rules. It changes the benefits. The new law is a massive, 1500-page document with complicated and far-reaching effects. If you don't know what it involves — and even if you do — we can help you.

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William Blair McIver, M.D.

Maui Memorial Hospital
Wailuku, Maui 96793

ANESTHESIOLOGY



Anthony S.Y. Seto, M.D.

23 South Vineyard Street
Honolulu, Hawaii 96813

PSYCHIATRY



Ronald D. Ah Loy

2163 Pauoa Road
Honolulu, Hawaii 96813

SPECIAL AFFILIATE (STUDENT)



Charles Conloy Ching, M.D.

1481 South King Street
Honolulu, Hawaii 96814

FAMILY PRACTICE
THORACIC SURGERY



Gerald A. Hiatt, M.D.

839 South Beretania Street
Honolulu, Hawaii 96813

INTERNAL MEDICINE
GASTROENTEROLOGY



Review of Medical Pharmacology, By Meyers Jawetz and Goldfien, 5th edition, Lange Medical Publications, Palo Alto, California Price: \$12.50.

The latest edition of this excellent series of soft cover reviews offers good value for a modest price.

It is comforting to have available such a concise, up-to-date, well-indexed, and clinically oriented pharmacology text.

Strongly recommended.

W. PHILIP JONES, M.D.

continued next page



BLEMISHES?

COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

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OF HAWAII

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FOR GOOD THINGS IN SMALL PACKAGES

Speak Up For Legislation That Can Save Your Business Up To 30% In Annual Insurance Premiums.

A bill permitting the sale of Commercial Multi-Peril (CMP) insurance packages in the State of Hawaii is before the current Legislature. Your support of it can mean a savings of time and money for your firm in the future.

CMP insurance packages are much like homeowner's policies for individuals, which are already legal here. They enable you to combine all your required business insurance coverages, except worker's compensation and car insurance, under a single policy. In the 49 states where CMP packages are legal now, the discount on the combined coverages ranges between 5 and 30%. And the package-policy concept means less paperwork for you and affords less danger of gaps and overlaps in your coverage.

The benefits to businesses offered by CMP packages are long overdue in Hawaii. Let your State Senator and your State Representative hear from you **NOW** so they'll know you support this legislation.

Once CMP Legislation is passed, you can combine any or all of the following coverages under a single policy:

Fire and extended coverage / Business interruption coverage / Glass / Public liability / Burglary and robbery / Inland marine / Fidelity / Boiler/machinery.

For more information about CMP package policies and their benefits, contact your insurance agent or Charles Jones, C.P.C.U., General Agent for the State of Hawaii, State Farm Insurance Companies, 1024 Mapunapuna St., Honolulu, Hawaii 96819, 839-0371.

Current Obstetric & Gynecologic Diagnoses & Treatment

By Ralph C. Benson, M.D., and associate authors, Lange Medical Publications, Los Angeles, CA 94022, 1976. Price: \$16.00.

As one who relied heavily, during medical school, internship, and military service, on the Lange series of handbooks and reviews, it is a pleasure to examine this latest publication in the Lange series. More than an expanded version of the familiar handbook of obstetrics and gynecology by Dr. Benson, this book is an entirely new textbook of obstetrics and gynecology. Dr. Benson has enlisted the aid of 42 associate authors, most of them internationally recognized experts in their fields, and many of them authors of textbooks in their own rights. We see familiar names such as Collins, Isreal, Jones, Tatum, and Woodruff, to mention only a few of the distinguished contributors.

The individual chapters are held to more or less of an outline form which minimizes the stylistic problems often seen with multi-authored texts. The book is liberally illustrated with line drawings and with many useful charts and tables.

The editor's aims in presenting this new textbook are to prepare a useful book for medical students, for family practitioners, and specialists in obstetrics and gynecology; to keep the text within economical bounds; to present a current review of the literature for those who wish more complete and comprehensive discussion of specific problems; to set forth principles of gynecologic surgical technique; and to cover preventive aspects of disease. I feel the authors and editor have done an excellent job in this regard.

The text follows the familiar textbook outline of embryology, anatomy, physiology, then proceeds through abnormal and normal menstruation, sex chromosome abnormality, congenital anomalies, through consideration of diseases of the vulva, vagina, cervix, corpus, oviducts, ovaries, etc. An extensive review of obstetrics includes consideration of applied genetics, complications of pregnancy, labor, and delivery, evaluation of the newborn infant, operative delivery, abortion, and sterilization. It is a pleasure to see chapters on emotional aspects of pregnancy and psychological aspects of gynecologic practice, in addition to a chapter on marriage, marital counseling, and sex therapy.


It is the publisher's intention to bring out a new edition of this book at two year intervals.

The only shortcoming of the book is that it is too large to fit in a lab coat pocket, extending to over 870 pages of text. An excellent index allows for quick reference. I feel this book will soon earn a place on every delivery floor.

KENNETH A. PRUETT, M.D.

Our "Angels"

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Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

New Members—**Mona R. Bomgaars MD** has been accepted as a new Active member; she is with the Health Manpower Development Staff in the Dean's office at the UH Sch of Med; she is a diplomate of the ABFP (1972). New Student member is **Joseph T. Gilhooly**, UHSM '80. So is **Clive Otsuka**. Welcome!

News of Members—The **Boido's** have said farewell to Hawaii as of 1 Feb and Vernon hopes to practice in a Mexican-American community in the Los Angeles area. We wish them Godspeed! **Bob Benson** has been approved for Life membership, having reached age 70; he has been a member since 1951 (charter). **Norina D'iorio** has transferred to Forty Ft Pennsylvania. **Seiichi Miyasaki** of Haleiwa has been granted Life status at the age of 72; he too was a charter member (1951). As the older members become Life, the Student members increase in numbers and soon will have a majority in the Hawaii Chapter! The **Liljestrands** will be away until May.

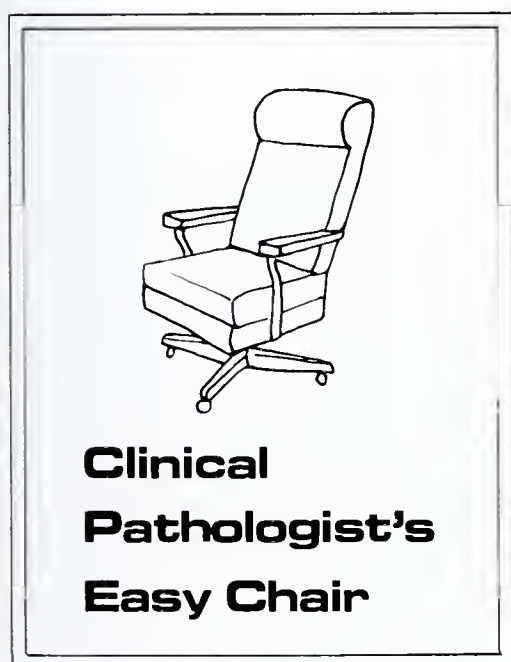
Annual Meeting—We were honored by the presence of **Les Huffman**, President of the American Academy of Family Physicians, and his wife, at our annual meeting on 15 January. It was a cheerful gathering of 67 people, including 28 members, one a student, at The Willows. Pres. **Huffman** installed the new officers: Pres. **Lincoln Luke**, Pres-elect **Tom Cahill**, Sec'y **Patricia Dietrich**, Treasurer **Fred Reppun**, and new Councilmen: **Fred Dodge**, **Mike Hase**, **Doris Jasinski**, **Glenn Stahl**, and **Dave Swanson**, Col. MC; **Lafferty** and **Reppun** were elected Delegates to the Congress, AAFP, which meets in Las Vegas in October.

Council Meeting—at Children's Hospital at noon on 20 January. The Constitution and ByLaws that had been approved as revised and updated at the Annual Meeting, were signed by the officers and are to be transmitted to Hq in Kansas City for approval by the AAFP. The names of **Pat Walsh** and **Tom Cahill** were submitted for possible election to the Board of the ABFP. Pres. **Lincoln Luke's** appointments to committee chairmanships were approved by the Council: Legislative—**Dietrich**; Mental Health: **Lafferty**; Education: **Lafferty** with the assistance of **Dodge**; Health Care Services: **Cahill**; Cancer: **L. Luke**; ByLaws: **Reppun**; Public Health & Scientific Affairs: **Glover**. The Council took a stand on proposed legislation to delete the premarital VDRL: It favored the deletion, re-

emphasized the requirement in the law as regards a real premarital physical examination, and suggested that it be in the law that the woman be given the HAI test for sensitivity to Rubella; the Council felt that the requirement for all prenatales to have a VDRL test was adequate protection against the spread of Syphilis; data indicates that out of 43,293 premarital tests, only 2 cases of early infectious Syphilis were found.

CME—The Hawaii Chapter is one of 35 which will have a computerized compilation of members' credit hours. This will start in mid-March. Each member will receive a packet of cards and instructions from Hq. The **HAWAII MEDICAL JOURNAL** comes out monthly and has a complete listing of up-coming credit hours from courses, etc.

Next Meeting for dinner 26 March at the Reppun's.



Magnesium

Magnesium, the fourth most abundant cation in the body, is second only to potassium intracellularly. There are approximately 25 grams in the normal human adult, about half of this found in bone.¹ There are approximately 1.3 to 2.1 mEq/l (1.6 to 2.3 mg/dl) in serum, about one-third bound to protein. Since serum magnesium represents only a small fraction of the total body stores, this measure will not give a true indication of the total body stores.

The average daily intake of magnesium in a normal diet is about 25 mEq, mostly as part of chlorophyll. Most of the magnesium is absorbed by the small intestine, although some can be absorbed by the colon, as seen with magnesium sulfate enemas. Calcium influences magnesium absorption by competition for a common absorptive pathway. About one third of the absorbed magnesium is excreted in the urine and this excretion decreases with lowered intake.

Magnesium is an activator of most vital enzyme systems. It appears to be essential for the proper mobilization of calcium from bone and soft tissues, and for the intracellular retention of potassium.² Magnesium and calcium have interdependent influences on the excitability of the neuromuscular apparatus, and depletion causes increased excitability and enhanced neuromuscular transmission.

Hypermagnesemia is most commonly seen in acute and chronic renal failure, and also in patients undergoing hemodialysis, and after overzealous therapeutic administration of magnesium salts. Symptoms are due to impaired neuromuscular transmission that resembles a curare effect. Cardiac conduction is affected at 5 to 10 mEq/l, and cardiac arrest occurs in diastole with over 25 mEq/l.

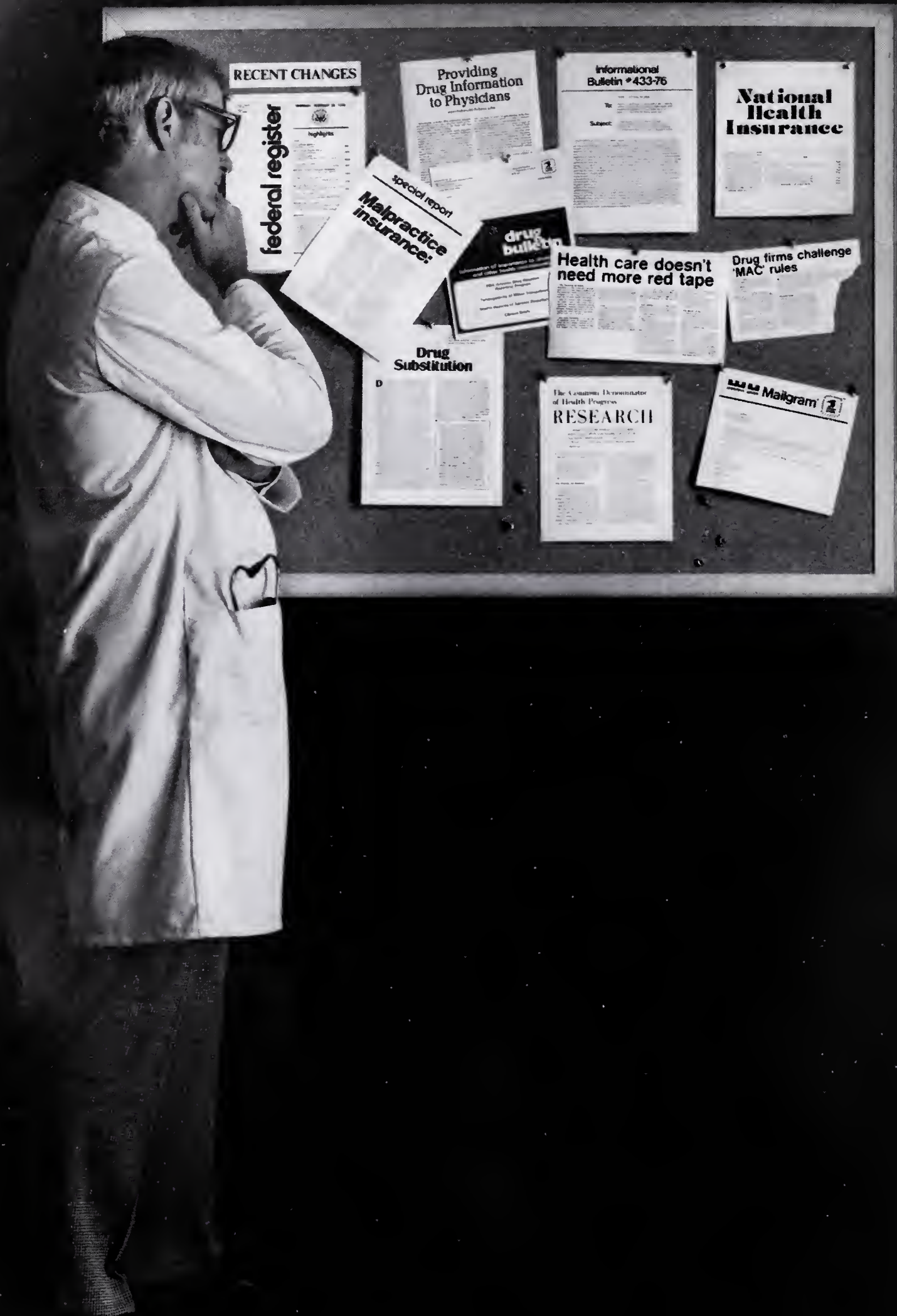
Magnesium deficiency leads to neuromuscular hyperexcitability and behavioral disturbances. Symptoms may be vague, or manifested by weakness, tremors, stupor, nausea, vomiting, and anorexia, but may also include tetany, generalized or focal seizures, ataxia, vertigo, depression, irritability, and psychotic behavior. The most distinctive symptom of hypomagnesemia with normal calcium and blood pH is tetany. The serum levels are usually of less than 1 mEq/l.

Symptomatic hypomagnesemia is most often seen in disorders associated with steatorrhea such as non-tropical sprue.³ Deficiency can occur in congestive heart failure, after diuresis with furosemide, ethacrynic acid and mercurials, and with digitalis intoxication.⁴ Magnesium deficiency in patients receiving digitalis causes an increased incidence of arrhythmias. Deficiency is also seen in alcoholic cirrhosis, alcoholism with delirium tremens, diabetic acidosis, thyrotoxicosis, hyperaldosteronism, hyperparathyroidism, following the starvation and trauma of surgical procedures, with intravenous fluid replacement and gastric loss,⁵ in infants with protein-calorie malnutrition (Kwashiorkor), and in malignant osteolytic metastases where there is frequently an associated hypercalcemia.

The method used to determine serum magnesium is important because most colorimetric methods are not very precise nor accurate. The method of choice in clinical laboratories is by atomic absorption spectrophotometry.

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RECENT CHANGES

federal register

Providing Drug Information to Physicians

Informational Bulletin #433-76

National Health Insurance

special report
Malpractice insurance:

drug bulletin

Health care doesn't need more red tape

Drug firms challenge 'MAC' rules

Drug Substitution

RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



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Hawaii Medical Service Association

MARCH 1977
VOL. 36, NO. 3

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Valium (diazepam) is a benzodiazepine with a character all its own.

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But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



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The vulnerable ages

The first epileptic seizure is most likely to occur during early childhood and at the onset of puberty

About 9 out of 10 epileptics experience their first seizure before the age of 20—with the highest incidence between 5 and 7, when children start school, and at the onset of puberty, a time of physiological and psychic turmoil.¹ The most common type, grand mal, occurs in approximately 75% of epileptic children,¹ and more than 50% of patients who suffer initially from petit mal develop grand mal seizures before they reach the age of 16.²

Mysoline (primidone) for control of grand mal, psychomotor and focal epilepsy

At the onset and afterwards—used alone or as concomitant therapy, MYSOLINE may reduce the frequency and severity of major motor seizures—or even eliminate them. *Excellent* for control of grand mal. Valuable for control of psychomotor^{1,3,4} and focal epilepsy as well.⁵

Add Mysoline when control with other anticonvulsants is inadequate—As concomitant therapy, MYSOLINE can improve seizure control in grand mal and psychomotor epilepsy. The combined use of phenobarbital, diphenylhydantoin, and MYSOLINE may have additive anticonvulsant effects without additive side effects.⁶

Change to Mysoline when other anticonvulsants fail—A changeover to MYSOLINE is frequently warranted when other anticonvulsants must be discontinued because of important side effects, or when grand mal seizures are refractory to phenobarbital, with or without diphenylhydantoin.⁷

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Mysoline® (primidone)

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50 mg.
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better life for the epileptic**

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BRIEF SUMMARY

(For full prescribing information, see package circular.)

MYSOLINE® Brand of PRIMIDONE Anticonvulsant

ACTIONS: MYSOLINE acts on the central nervous system to raise seizure threshold or alter seizure pattern. The mechanism(s) of action of anticonvulsant drugs is not known.

Primidone has anticonvulsant activity *per se*. In addition, its two metabolites possess anticonvulsant qualities. The major metabolite is phenylethylmalonamide (PEMA); the other is phenobarbital. In addition to its own anticonvulsant potential, PEMA potentiates phenobarbital.

INDICATIONS: MYSOLINE, either alone or used concomitantly with other anticonvulsants, is indicated in the control of grand mal, psychomotor, and focal epileptic seizures. It may control grand mal seizures refractory to other anticonvulsant therapy.

CONTRAINDICATIONS: Primidone is contraindicated in: 1) patients with porphyria and 2) patients who are hypersensitive to phenobarbital (see ACTIONS).

WARNINGS: The abrupt withdrawal of antiepileptic medication may precipitate status epilepticus.

The therapeutic efficacy of a dosage regimen takes several days before it can be assessed.

Use in pregnancy: Recent reports strongly suggest an association between the use of anticonvulsant drugs by women with epilepsy and an elevated incidence of birth defects in children born to these women. Reference has been made to primidone in several cases in which it was used in combination with other anticonvulsants; but its teratogenicity has not been conclusively demonstrated. The possibility exists that other factors, e.g., genetic factors or the epileptic condition, may contribute to the higher incidence of birth defects. The data also indicate that the great majority of mothers receiving anticonvulsant medication deliver normal infants.

Anticonvulsant drugs should not be discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and risk to both mother and the unborn child.

When the nature, frequency, and severity of the seizures do not pose a clear threat to the patient, good medical practice requires that the physician weigh the expected therapeutic benefit of anticonvulsant therapy against possible risk on an individual basis.

Neonatal hemorrhage, with a coagulation defect resembling vitamin K deficiency, has been described in newborns whose mothers were taking primidone and other anticonvulsants. Pregnant women under anticonvulsant therapy should receive prophylactic vitamin K₁ therapy for one month prior to, and during, delivery.

The physician should weigh all of the foregoing considerations when treating and counseling epileptic women of childbearing potential.

PRECAUTIONS: The total daily dosage should not exceed 2 Gm. Since MYSOLINE therapy generally extends over prolonged periods, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

In nursing mothers: There is evidence that in mothers treated with primidone, the drug appears in the milk in substantial quantities. Since tests for the presence of primidone in biological fluids are too complex to be carried out in the average clinical laboratory, it is suggested that the presence of undue somnolence and drowsiness in nursing newborns of MYSOLINE-treated mothers be taken as an indication that nursing should be discontinued.

ADVERSE REACTIONS: The most frequently occurring early side effects are ataxia and vertigo. These tend to disappear with continued therapy, or with reduction of initial dosage. Occasionally, the following have been reported: nausea, anorexia, vomiting, fatigue, hyperirritability, emotional disturbances, sexual impotency, diplopia, nystagmus, drowsiness, and morbilliform skin eruptions. Occasionally, persistent or severe side effects may necessitate withdrawal of the drug. Megaloblastic anemia may occur as a rare idiosyncrasy to MYSOLINE and to other anticonvulsants. The anemia responds

to folic acid, 15 mg. daily, without necessity of discontinuing medication.

DOSAGE AND ADMINISTRATION: The average adult dose is 0.75 to 1.5 Gm. per day. The initial dose is 250 mg. Increments of 250 mg. are added, usually at weekly intervals, to tolerance, or therapeutic effectiveness, up to daily doses not exceeding 2.0 Gm. A typical dosage schedule for the introduction of MYSOLINE (primidone) is as follows:

Adults and Children Over 8 Years of Age

1st Week 250 mg. daily at bedtime	2nd Week 250 mg. b.i.d.
3rd Week 250 mg. t.i.d.	4th Week 250 mg. q.i.d.

In children under 8 years of age, maintenance levels are established by a similar schedule, but at one-half the adult dosage. It is best to begin with 125 mg., with gradual weekly increases of 125 mg. a day, to a daily total usually between 500 mg. and 750 mg.

In patients already receiving other anticonvulsants: MYSOLINE should be gradually increased as dosage of the other drug(s) is maintained or gradually decreased. This regimen should be continued until satisfactory dosage level is achieved for combination, or the other medication is completely withdrawn. When therapy with this product alone is the objective, the transition should not be completed in less than two weeks.

MYSOLINE 50 mg. Tablet can be used to practical advantage when small fractional adjustments (upward or downward) may be required, as in the following circumstances:

- for initiation of combination therapy
- during "transfer" therapy
- for added protection in periods of stress or stressful situations that are likely to precipitate seizures (menstruation, allergic episodes, holidays, etc.)

HOW SUPPLIED: MYSOLINE Tablets—No. 430—Each tablet contains 250 mg. of primidone (scored), in bottles of 100 and 1,000. Also in unit dose package of 100. No. 431—Each tablet contains 50 mg. of primidone (scored), in bottles of 100 and 500. MYSOLINE Suspension—No. 3850—Each 5 cc. (teaspoonful) contains 250 mg. of primidone, in bottles of 8 fluid ounces.

References: 1. Livingston, S.: Comprehensive Management of Epilepsy in Infancy, Childhood and Adolescence, Springfield, Ill., Charles C Thomas, 1972, pp. 6, 7, 584. 2. Grossman, H.J.: Ill. Med. J. 135:260 (Mar.) 1969. 3. Scholl, M.L., in Conn, H.F.: Current Therapy 1973, Philadelphia, Saunders, 1973, pp. 675-7. 4. Metrick, S.: C.M.D. 37:49 (Jan.) 1970. 5. Forster, F.M.: Med. Clin. North Am. 47:1579 (Nov.) 1970. 6. White, P.T.: Wis. Med. J. 68:178 (Apr.) 1969. 7. Millichap, J.G.: Drug Ther. 1:15 (Oct.) 1971.



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I N V E S T M E N T O F A F E W M I N U T E S

Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

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Contraindications: Hypersensitivity to hydroxyzine. Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit, induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate to establish safety in early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as meperidine and barbiturates. In conjunctive use, dosage for these drugs should be reduced. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

Supply: Tablets, containing 10 mg, 25 mg, or 50 mg hydroxyzine hydrochloride, 100's and 500's; Tablets, containing 100 mg, 100's; Syrup, containing 10 mg per teaspoonful (5 ml) and ethyl alcohol 0.5% v/v, pint bottles.

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Immunotherapy of Carcinoma of the Stomach: A Status Report

E.M. EDYNAK, M.D., N. OISHI, M.D., B.L. GORDON, M.D., and
A. DEICH, M.D., *Honolulu*

• *Stomach cancer is a particularly aggressive tumor, with poor prognosis. Each year in the state of Hawaii, 150 to 200 new cases are reported. The overall five-year survival, pooling patients with all stages of disease, is 9% for men and 11% for women.¹ Less than 12-16% of patients with regional disease will survive 5 years. Of patients resected for cure, with evidence of only local nodal involvement, approximately 30-80% will be dead in one year (N₁ versus N₂ disease).²*

It is thus evident that the diagnosis of carcinoma of the stomach carries a poor outlook. With this in mind, in an attempt to reduce the high mortality from this disease, the following study was initiated.

Materials and Methods

Gastric carcinomas and other tissue specimens were obtained at postmortem examination within 12-24 hours of death or at time of surgical resection, and stored at -70°C until processed. Gross tumors were separated from surrounding normal tissue, minced by hand and homogenized in a Virtis high-speed blender in iced distilled water. The suspension was centrifuged at 10,000 RPM in the refrigerated centrifuge (Sorval RC2B). Cellular membrane fragments were then subjected to a solubilization with 3M KCl salt solution for 24 hours.³ The salt solution containing the solubilized membrane antigens was dialyzed in distilled water for 24-36 hours. The resulting solution was either freeze dried (lyophilized) or concentrated by ammonium sulphate precipitation and passed twice through a

millipore filter. Final concentration of the solubilized membrane antigens reconstituted in distilled water was approximately 20-40 mg/ml. All vaccines were tested and found negative for HAA (hepatitis associated antigens) and for bacterial contamination.

Ten patients with gastric carcinoma at high risk of recurrence, (TNM staging T₂₋₃N₁₋₂M₀₋₁) were referred from the Kaiser, Leeward, Queen's, Tripler, and Kuakini Medical Centers. Ten patients matched for age, sex, and stage of disease were obtained from the Hawaii Tumor Registry to serve as a control group.

Patients undergoing definitive resection were evaluated with immunologic profiles within 4-6 weeks of surgery. *In vivo* skin testing was performed to recall antigens including PPD, mumps, mixed bacterial flora, trichophyton, and candidin. Additional skin testing was performed with phytohemagglutinin and the pooled allogeneic cancer vaccine. In addition, patients were evaluated by *in vitro* lymphocyte stimulation testing to common mitogens including pokeweed mitogen (PWM), phytohemagglutinin-P (PHA-P), and phytohemagglutinin-M (PHA-M), and concanavalin-A (con-A) by a whole blood cell culture technique originally described by Ferket⁴ and modified by Gordon. Leukocyte adherence inhibition assays⁵, *in vitro* lymphocyte stimulation by the solubilized tumor antigen⁶ and semi-quantitative analysis of T and B cell populations were performed prior to initiation of therapy and twice monthly thereafter.

Immunotherapy Protocol

Patients were seen weekly. On alternate weeks patients underwent *in vitro* lymphocyte stimulation testing as described above. Twice monthly,

The Department of Surgery and Medicine, the Queen's Medical Center of the University of Hawaii, the Kuakini Medical Research Institute, and the Clinical Science Division Cancer Center of Hawaii

Accepted for publication January, 1976.

TABLE 1.—Immunotherapy of Patients with Gastric Cancer

SURGERY & IMMUNOTHERAPY					SURGERY ALONE				
PATIENT	AGE	SEX	STAGE OF DISEASE	TIME OF SURVIVAL (MONTHS)	PATIENT	AGE	SEX	STAGE OF DISEASE	TIME OF SURVIVAL (MONTHS)
1	47	F	T ₃ N ₂ M ₀	20 +	11	45	F	T ₃ N ₂ M ₀	12 D
2	67	M	T ₂ N ₁ M ₀	20 +	12	68	M	T ₂ N ₁ M ₀	10 D
3	46	F	T ₂ N ₂ M ₁	20 +	13	43	F	T ₂ N ₂ M ₁	8 D
4	42	M	T ₃ N ₁ M ₀	13 +	14	43	M	T ₃ N ₁ M ₀	10 +
5	56	F	T ₂ N ₁ M ₀	13 +	15	58	F	T ₂ N ₁ M ₀	12 R
6	49	M	T ₃ N ₂ M ₀	12 +	16	43	M	T ₃ N ₂ M ₀	10 D
7	45	M	T ₂ N ₁ M ₀	9 +	17	47	M	T ₂ N ₁ M ₀	10 R
8	54	M	T ₂ N ₁ M ₀	6 +	18			T ₂ N ₁ M ₀	6 +
9	57	F	T ₃ N ₁ M ₀	4 +	19	61	F	T ₃ N ₁ M ₀	4 +
10	46	M	T ₃ N ₂ M ₀	4 +	20	45	M	T ₃ N ₂ M ₀	4 +

(+): Alive without recurrence at time of report
D: Deceased
R: Alive with recurrence

patients received 0.1 ml tumor vaccine of solubilized tumor antigens (2-4 mg)±0.1 ml of Tice BCG (10 × 10⁶ organisms) if their previous lymphocyte stimulation assays indicated acceptable immune competence. Vaccine was administered intradermally over the deltoid areas, alternating sides.

Results

Within the immunotherapy treatment group, three patients were alive and well 20 or more months after surgery. Two patients had been treated for 13 months, one patient for 12, and one patient for 9 months. All patients in the treatment group as of this report were not only alive and well, but are free of disease as evidence by a one-year evaluation of repeat gastroscopy, upper gastrointestinal series, liver profiles, or scans when so indicated.

In contrast, of 10 patients matched for age, sex, and stage of disease in the control group, 4 patients were dead; of the 6 survivors, 2 had recurrent disease (Table 1).

In vivo skin tests revealed a positive skin test to the solubilized tumor vaccine preparation in all patients so immunized. Leukocyte adherence inhibition assays demonstrated apparently good cellular immunity with some cross reactivity to

solubilized antigens of colon carcinoma, but not to normal extracts of gastric nor colonic mucosa. It might be that the observed crossover reaction could be explained by the presence of mutual fetal or embryonic antigens shared between various tumors.

Complications of Immunotherapy

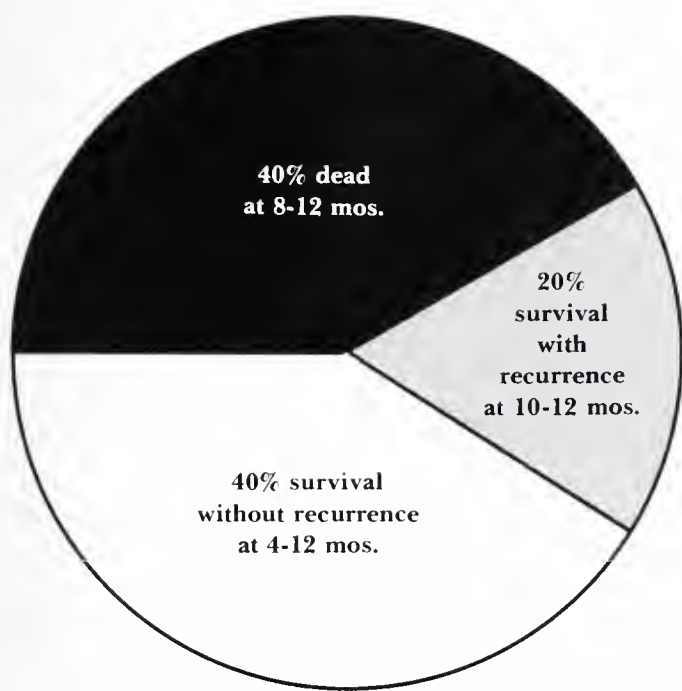
The complications of immunotherapy involving BCG include: 1) development of a transient flu-like syndrome with chills, fever, myalgia; 2) development of ulcerative lesions at the site of administration of BCG vaccine; 3) development of BCG-osis or granulomatous hepatitis; or 4) theoretical acceleration of tumor growth (Table 2). In these 10 patients, in addition to approximately 50 additional patients being treated for a variety of other malignancies, the incidence of flu-like illness after the administration of BCG ranges from 40-60%; however, this flu-like syndrome is readily amenable to treatment with aspirin or acetaminophen. Patients under treatment have developed skin ulcerations with repeated intradermal injections of BCG, with eventual sinus formation. Patients undergoing therapy have not felt this to be an obstacle to treatment. The incidence of granulomatous

TABLE 2.—Complications of Patients Undergoing BCG Immunotherapy

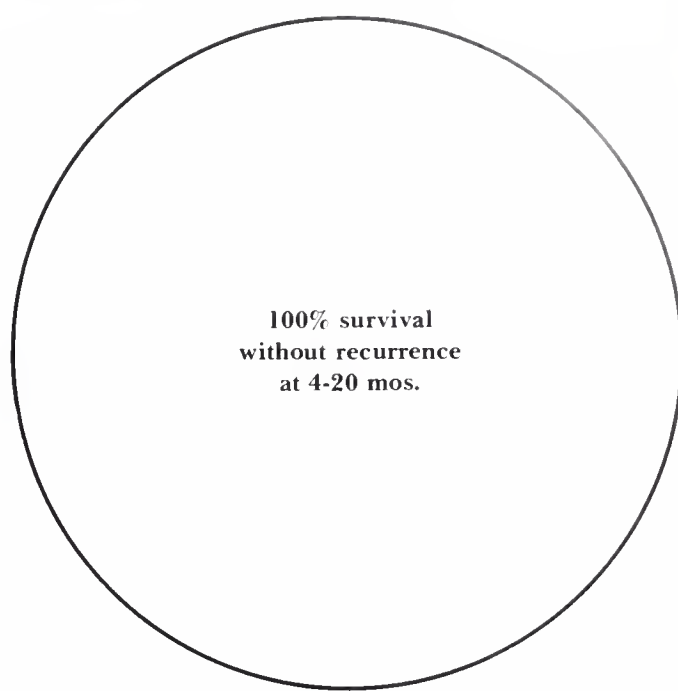
	MODE OF ADMINISTRATION		
	INTRALESIONAL	BCG + VACCINE (intradermal)	BCG ALONE (intradermal)
Malaise	4/10	14/25	12/24
Temperature elevation	10/10	22/25	23/24
Chills/Sweats	10/10	21/25	20/24
Ulceration at injection site	6/10	23/25	18/24
Adenopathy	4/10	8/25	6/24
Hepatic dysfunction	0/10	0/25	1/24*

*Received BCG at time when lymphocyte stimulation tests were below lower limits of normal.

FIG. 1.—Comparison of current status of 20 patients with gastric carcinoma, stage III. Group A treatment consists of surgery alone, group B treatment consists of immunotherapy following surgery. The 10 patients in each group were matched for stage of disease at time of operation, age, sex, and race.



A. SURGERY ALONE.
(10 PATIENTS)



B. IMMUNOTHERAPY
FOLLOWING SURGERY
(10 PATIENTS)

hepatitis or BCG-osis ranges from 10-58% according to Sparks⁷ and Pinsky⁸. We have treated over 60 patients for varying malignancies with BCG alone and in combination with tumor vaccine, adhering to a rigid standard of a minimally acceptable immune competence as a criterion for the administration of BCG. We have not seen a single case of granulomatous hepatitis in those patients.

In our treatment of more than 60 patients, no evidence was seen of tumor enhancement or facilitation of tumor growth. Although this is a theoretical consideration and has been reported in the literature in unusual animal systems, there have been no reports of facilitated tumor growth in the thousands of patients currently undergoing BCG therapy throughout the world.

Conclusion

This preliminary report indicates promise in immunoprophylaxis of patients with gastric carcinoma. As seen in Figure 1, the comparison of both groups suggests a real difference between

the group receiving adjuvant immunotherapy and the control group receiving surgery alone. This study, with its small numbers of patients, may not be of statistical significance. However, survival curves reported by Kennedy² and data obtained from the Hawaii Tumor Registry indicate that patients with stage 2-3 disease treated with surgery alone will experience a 30-80% mortality in one year.

This study indicates that patients tolerate immunotherapy well without acceleration of tumor growth or early recurrence. Alternatively, it may be that such treatment is effective in the prevention of recurrent disease. The statistical significance of this study will only be substantiated by larger numbers of patients followed over a longer time.

Acknowledgement

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The Earlobe Crease—Sign of Obesity in Middle-aged Japanese Men

GEORGE G. RHOADS, M.D., M.P.H., KEITH KLEIN, M.D.,
KATSUHIKO YANO, M.D. and HENRY PRESTON, M.D., *Honolulu*

• *Several reports have recently suggested that the presence of a deep crease extending downward across the earlobe is indicative of coronary heart disease (CHD).¹⁻³ Lichstein et al. studied 531 patients hospitalized in a coronary care unit with acute myocardial infarction and found that 47% of them exhibited a diagonal earlobe crease, as compared to 30% of a group of hospital controls.² Analysis of their data in the usual case-control format suggests that coronary disease is found more than twice as often in men with the crease as in men without it.*

Sternlieb et al examined 144 patients who were scheduled for coronary arteriograms and found that 90% of 133 patients with the crease had coronary artery disease, while only one of eleven patients without the crease had diseased coronaries.³ On the other hand, Mehta and Kamby examined the earlobes of 211 consecutive patients undergoing coronary arteriography and found no significant correlation between creases and coronary artery disease.⁵

These reports are characterized by substantial lack of consistency as to the frequency and significance of an earlobe crease. Independent assessment of earlobe creases and coronary disease has not been assured. Moreover, none of these studies has been based on a normal population nor has adequately examined the relationship of earlobe creases to other coronary risk factors. The present study was designed to address some of these questions.

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Methods

This investigation was carried out at the Honolulu Heart Study, a population-based cohort study of CHD and stroke in Japanese-American men. The recruitment of the cohort⁶ and laboratory methods^{7,8} have been previously described. Eight thousand men attended the initial examination in the years 1965-1968. These participants were called back for a second examination two years later and for a third examination six years after their initial visit. At each visit they were assessed for the presence of CHD according to published criteria.^{9,10} Observations for earlobe creases were carried out consecutively on 1,237 men who attended the third examination during the last nine months of 1974. Earlobes were scored by one of three technicians who were unaware of the status of the subjects with respect to coronary heart disease. Each man was examined in the upright position, as it was noted that the crease could be produced in certain men by having them lie supine. A crease was considered to be present if it appeared to involve the full skin thickness, extended entirely across the earlobe, and was directed downward from its superior origin between the inter-tragic notch and the posterior extent of the antitragus. Both ears were scored, and subjects with a crease on at least one ear were considered positive for purposes of this study. Creases which did not extend all the way across the earlobe and superficial lines were noted separately.

Results

Of the 1,237 men examined, 393 were found to have an earlobe crease, giving an overall prevalence rate of 31.8%. Prevalence estimates for the three technicians showed some variation, being

29, 30 and 37 percent. An additional 50% of the men had faint lines or incomplete creases on one or both ears, and inevitably the distinction between these marks and a codable crease was sometimes difficult. Each technician saw a reasonably representative third of the population, and we believe that the differences in prevalence rates resulted from small differences in interpretation among the technicians.

Of the men included in this study, 71 turned out to have CHD. These were comprised of 37 who had sustained a definite myocardial infarction and 34 who had suffered attack(s) of coronary insufficiency or angina pectoris. Earlobe creases were found in 21 (29.6%) of the 71 men, which is nearly identical to the experience in the general population (Table 1). Among men with myocardial infarctions the prevalence rate was 22%. The relative risk of having CHD among men with creases, when compared to men without creases, is 0.9 with approximate 95% confidence limits of 0.5-1.5.⁴ There was no consistent trend of earlobe crease prevalence with age in these older men.

Selected attributes of men with and without creases are shown in Table 2. The men with

creases were fatter than those without creases, whether obesity was measured by skinfold thickness, absolute weight, or by relative weight (adjusted for height).⁸ A small difference in height was also noted. Among the other coronary risk factors, only systolic blood pressure was clearly elevated in men with a crease. Borderline relationships were noted for diastolic blood pressure and serum uric acid. Adjustment of the Table 1 mean values for the technician differences noted above (using a procedure analogous to direct age-adjustment) produced only trivial changes, in no case altering a mean value by as much as 0.25%.

The inter-relationships among these variables were investigated by carrying out a discriminant function analysis as shown in Table 3. In this multivariate setting with four independent variables considered simultaneously, relative weight remained highly significantly related to the presence of a crease, systolic blood pressure was of borderline significance, and uric acid appeared unrelated. This suggests that the relation of blood pressure to the earlobe crease was at least partly explained by other factors, particularly obesity.

TABLE 1.—Earlobe Crease Prevalence by Age and Coronary Heart Disease Status.

AGE (YEARS)	NO CHD		CHD	
	TOTAL NO.	% WITH CREASE	TOTAL NO.	% WITH CREASE
50-54	174	25.3	8	37.5
55-59	418	32.5	26	23.1
60-64	255	35.7	15	20.0
65-59	219	34.2	10	40.0
70-74	100	26.0	12	41.7
Total	1,166	31.9	71	29.6

TABLE 2.—Selected Attributes of Men With and Without Earlobe Creases.

ATTRIBUTE	CREASE (393 MEN)		NO CREASE (844 MEN)		SIGNIFICANCE LEVEL*
	MEAN ± S.D				
Age (years)	62.1	± 5.6	61.7	± 5.9	NS
Height (cm)	163.3	± 5.8	162.6	± 6.1	<.02
Weight (kg)	64.0	± 9.7	61.4	± 10.0	<.001
Relative weight (%)	113.4	± 14.9	109.7	± 15.0	<.001
Triceps skinfold (mm)	8.1	± 3.4	7.6	± 3.2	<.02
Subscapular skinfold (mm)	16.8	± 6.4	15.2	± 6.6	<.001
Systolic blood pressure (mm Hg)	140.4	± 21.0	137.2	± 20.6	<.02
Diastolic blood pressure (mm Hg)	84.5	± 11.1	83.3	± 11.3	<.10
Hematocrit (%)	43.9	± 3.4	43.7	± 3.0	NS
Cholesterol (mg/dl)	209.4	± 38.1	211.3	± 36.9	NS
Triglyceride (mg/dl)†	230.7	± 146.4	220.7	± 162.6	NS
Uric acid (mg/dl)	6.46	± 1.49	6.29	± 1.50	<.10
Cigarettes/day	18.5	± 16.8	17.1	± 16.6	NS

*Two-sided t-test

†Non-fasting

TABLE 3.—Relation of Earlobe Creases to Selected Variables in a Discriminant Analysis.*

INDEPENDENT VARIABLE	T-TEST*	SIGNIFICANCE LEVEL
Relative weight	3.13	p<.01
Height	2.17	.01<p<.05
Systolic blood pressure	1.93	.05<p<.10
Serum uric acid	1.01	—

*The presence or absence of an earlobe crease was entered as the dependent variable. The t statistics indicate whether the coefficients differ significantly from zero.

Discussion

There is substantial room for disagreement in the classification of earlobe creases. Despite an effort to standardize observations, inter-technician differences in this study were greater than could be accounted for by chance. (They were also not explained by differences in obesity among the subjects seen by the different technicians.) Differences in interpretation may account for at least part of the differences in overall frequency of creases among various published reports. We have noted that the appearance of a crease can change markedly when a subject goes from an upright to a supine position. It seems apparent, therefore, that studies attempting to relate earlobe creases to disease status require that the observations be carefully standardized and that they be carried out in ignorance of the disease status of the subject.

Although there was no increase of crease prevalence with age in this group of older men, it seems likely that such an increase is found in younger persons. Anomalies of the earlobe are sufficiently uncommon in children to provoke special attention.¹¹ Prevalence was lower in the 30-39 year age group in the data of Lichstein et al,² and Mehta has reported a substantial difference in prevalence between persons above and below age 55.⁵ It seems likely, therefore, that prevalence increases sharply from childhood into the fifth or sixth decade of life and then levels off.

The occurrence of earlobe creases seems also to be related to obesity, whether measured by weight or skinfold thickness. This relationship appears to account for the borderline difference in uric acid levels which was noted, and it may also account for the difference in blood pressure. The increase of crease prevalence with age is not likely to be explained by obesity, since more than 20% of men even in the lowest quartile of relative weight had an earlobe crease.

The presence of an earlobe crease appears unrelated to the prevalence of CHD in these men of Japanese ancestry. Moreover, the upper 95% confidence limit of the relative risk was only 1.5,

which is substantially below the relative risk estimate of 2.1 which we calculated from the data of Lichstein et al,² and is totally inconsistent with the data reported by Sternlieb.³ It is possible that these differences are related to differing criteria or to differences in race, sex, or disease status among the populations studied. However, the earlobe creases in these men are consistent with the published photographs,^{1,2} and coronary disease in this population, although less common than in Caucasians,⁹ is pathologically typical.¹² We believe that the inconsistencies in the available evidence raise considerable doubt about the earlobe crease as a CHD indicator; it may be nothing more than an aural sign of obesity.

Summary

In a population-based study of coronary heart disease, 1,237 American-Japanese men, aged 50-74, were examined for the presence of earlobe creases. A definite crease on at least one ear was observed in 31.8%. The frequency of creases was not related to age, serum cholesterol, or cigarette smoking, but was positively related to obesity, systolic blood pressure, and height. The relation to blood pressure is at least partly explained by obesity. Coronary heart disease was present in 71 of the men, of whom only 29.6% had the crease.

We conclude that there is no important relation between an earlobe crease and coronary heart disease prevalence in this population, but that creases are especially common in fat men.

Acknowledgements

We are indebted to Mrs. Janet Baisac, Mrs. Mary Mikasa, and Mrs. Elaina Nakao for carrying out the earlobe crease observations.

Since preparation of this manuscript two additional studies of earlobe creases have come to our attention.^{13, 14} Both report an association of the crease with coronary heart disease, but in neither is it clear that the observations were made without knowledge of the disease status of the individual. The possible role of obesity was also not considered.

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JON WON

Note to HMA Members: Last month's Newsletter carried an announcement of the opening of a new family planning facility in our community. The HMA was requested to make this announcement; the HMA does not have any familiarity with the operation of this particular facility and, as such, does not endorse or support this new facility nor its programs by making the announcement. Physicians that do refer patients for family planning services and counseling would be wise to seek consultation with other colleagues, or it might be wise to check with the Hawaii Chapter of the American College of Obstetrics & Gynecology for appropriate advice.

New Undersecretary of DHEW, the number two position in DHEW, is Charles H. Champion, financial vice-president of Harvard University. Mr. Champion was former director of finance for the State of California, former vice-president of planning and operations at the University of Minnesota, former director of the Boston Redevelopment Authority, and former press secretary to Edmund G. Brown, former Governor of California.

To set the Records Straight, statements that "doctors fees have increased twice as fast as the cost of living," are not borne out by a Social Security Bulletin which shows the following for the Consumer Price Index:

	All Items	All Services	MD Fees	Total Medical Care
1967	100.0	100.0	100.0	100.0
1970	116.3	121.6	121.4	120.6
1976 (Sept.)	172.6	183.2	192.2	187.9

Interesting to note that during the same period, the maximum social security tax went from \$290.40/year to \$895.05 in 1976 and to \$965.25 in 1977: 1967 — 100.0; 1976 — 308.2; 1977 — 332.4.

The American Dental Association has been charged by the Federal Trade Commission (FTC) with illegally restraining competition among dentists by restricting advertising by dentists through its ethics codes. Named as defendants along with the ADA in the FTC complaint were the Indiana Dental Association, the Indianapolis District Dental Association, and the Northern Virginia Dental Society. The FTC said that each of the codes of ethics "fixes prices or otherwise interferes with the prices of dentists' services; deprives consumers of information pertinent to the selection of a dentist; (and) restrains the development of innovative systems for the delivery of dental services."

What the AMA Does Dollar Does is a report to physicians on the programs that 1976 AMA revenues supported. Of a total budget of \$42.9 million, the budget was divided as follows: 38.2% for Disseminating Scientific Information, such as journals, continuing medical education, audiovisual services, and AMA's library; 10% on Representing the Profession, in national health insurance debates, health manpower, health planning, utilization review, etc., etc.; 8.0% in Serving the Public in such areas as violence on TV positions and in improving medical care in jails; 17.7% in Assisting the Physician and His Practice in peer review, computer services, and socioeconomic research; 12.3% in Upgrading Care Through Educational Standards in participating in medical school accreditation, in graduate education, and in allied medical education; and 13.8% in Strengthening Organized Medicine.

The Wall Street Journal of Feb. 10, 1977, carries an article on Bureaucratese which includes classic government prose as follows:

"We respectfully petition, request and entreat that due and adequate provision be made, this day and the date hereinafter subscribed, for the satisfying of these petitioners' nutritional requirements and for the organizing of such methods of allocation and distribution as may be deemed necessary and proper to assure the reception by and for said petitioners of such quantities of baked cereal products as shall, in the judgment of the aforesaid petitioners, constitute a sufficient supply thereof."

The article goes on to say that this is the way a federal regulation writer might write, "Give us this day our daily bread." In essence, this is an example used in a class now being held for regulation writers from DHEW, FAA, OSHA, EPA, and other federal agencies in an effort to get regulations down to plain English by eliminating legalistic jargon, duplicating phrases, and other gobbledygook. Hooray! Let us all wish them much success!

Five Major U.S. Corporations announced recently that they will review their advertising policies concerning sponsorship of violent, prime-time TV programs. The five companies are Sears, Roebuck and Co.; General Motors Corp.; Joseph Schlitz Brewing Co.; Kraft Co.; and Samsonite Luggage. It is reported also that Union Oil Co. has instructed its ad agencies not to buy commercial time on violent TV programs. Public response to the AMA's stand on TV violence has been rapid and favorable.

Certificate of Need Controls don't work as they are supposed to, according to an analysis prepared for HEW. In fact, certificate of need controls "have contributed to cost inflation." David S. Salkever of John Hopkins University and Thomas W. Bice of Washington University said their study indicates that certificate of need controls reduce the expansion in beds while increasing the expansion in plant assets per bed "and had no discernible negative effects on total investment . . . In other words, certificate of need controls altered the composition of investment but not its magnitude."

The Study, titled Impact of State Certificate of Need Laws on Health Care Costs and Utilization, points to "the (perhaps) surprising conclusion that certificate of need controls have contributed to cost inflation: thus, they have tended to produce the very result which they were designed to prevent," the authors said. "At a minimum, our findings signal the need for much more thorough and detailed study of the effectiveness of certificate of need regulation as a cost-control device. The presumption of its effectiveness is clearly not warranted by the available evidence."

Happiness Is . . . Kauikeolani Children's Hospital Annual Benefit Show on Saturday, May 7, 1977, Pacific Ballroom of the Ilikai Hotel. Alan and Julie Grier will again headline a delightful show produced by Dr. Ed Kagihara and also featuring a mixed chorus, the Kauikeolani Keiki Singers and the Floating Ribs. Dr. George Taku-shi will provide the show and dance music of the "Torchers." Get your friends together—buy a table—and treat them to an evening of "Happiness!"

American Geriatric Society announces its 34th Annual Meeting, April 13-14, 1977, at the Fairmont Hotel in San Francisco. Features of this meeting include Nutrition, Rest, and Exercise. If interested, contact Walter M. Bortz, II, M.D., Palo Alto Medical Clinic, 300 Homer Ave., Palo Alto, Calif. 94301.

The Christchurch Hospitals Postgraduate Society announces a course entitled "Problems in General Surgery," September 19-21, 1977, in

New Zealand. Principal speakers are Professor Jerome DeCosse, Milwaukee, and Mr. Peter Hawley, St. Marks Hospital in London. Subject matter predominantly gastroenterological but a session on management of early breast cancer is planned. Further details obtained from Mr. Richard Stewart, University Department of Surgery, Christchurch Hospital, Christchurch, New Zealand. A postscript notes that the skiing season is at its height in September and there are six ski-fields within 70 miles of Christchurch.

Established Medical Office Space Available, Windward Oahu. Three suites approximately 750 sq. ft. each including common space. Two ground floor suites. All with shared expenses. Contact Mr. Rohrer, Ph. 262-6961.

Parking, Parking, Parking, Parking for HMA physicians and visitors has been enhanced since HMA's move to 320 Ward Avenue, but building tenants do have reserved stalls. *All HMA parking for physicians ONLY will have bright ORANGE STRIPES on curbs as well as an ORANGE CIRCLE painted on the ground.* Please try to use these stalls or the VISITOR STALLS that are available. Also remember that there are *three entrances* to HMA parking lots. Our building manager has instructions that unauthorized cars will be (and have been) towed away. Save \$25 by parking in proper stalls.



. . . long term iatrogeny

The medical profession is becoming increasingly aware of years-long later effects from both diagnosis and treatment of illness.

Way, way back the chirurgiens developed an evil and morbid reputation for themselves because of their obsession with treatments that invaded man's generally inviolate corpus—particularly blood-letting, cupping, the application of leeches, poulticing, exposing those with acute,

active tuberculosis to the fresh but cold elements of Winter up in Saranac, and in purging.

The developing science of medicine and surgery got us away from all that for a while, but we are now come full circle to being invasive of the body in making diagnoses, in addition to being invasive with treatments. Primum non nocere has become more the exception than the cardinal principle of "do no harm." In fact, the professional care for illness and injury has come to the point where the physician is at greater risk and hazard than his patient, particularly since the "consumer" and the attorney-at-law are playing footsie under the table.

Seriously, however, the practice of medicine has become increasingly difficult for the professional, as it has become more and more successful in the battle against disease, disability and death. The incidence of iatrogenic complications and ill effects has become frightening in its escalation; we pity the young medical student who proceeds nevertheless on the path to becoming a modern and burdened physician.

A recent FDA Drug Bulletin (Nov/Dec 1976) has an instance in point. The article is headed "Multiple Fluoroscopies and Breast Cancer." We quote briefly from it: "The Harvard study reaffirms that frequently repeated, relatively low radiation doses may incur some future risk of breast cancer, that the risk may be cumulative, and that multiple radiation doses may convey the same breast cancer risk as a single exposure of the same total dose."

This calls to mind the need for an Individual Cumulative Health Record that should be started when the infant is born, kept religiously up to date by parent or guardian, and turned over to him when he reaches majority for him to keep the rest of his life.

Voluntarily? Yes. Mandatory, by law, like a passport? Probably no, but maybe. It should not contain trivia; it should not be a xerox of a physician's office record, full of illegible hieroglyphics, or of transitory aberrant lab results. But, it should contain the significant medical data: (a) permanent family history of deceased members with periodic up-dating; (b) important and catastrophic events; (c) immunizations; (d) drug experience; (e) adverse reactions; and (f) a cumulative record of radiation received in rads to specific sites. These are to name but a few.

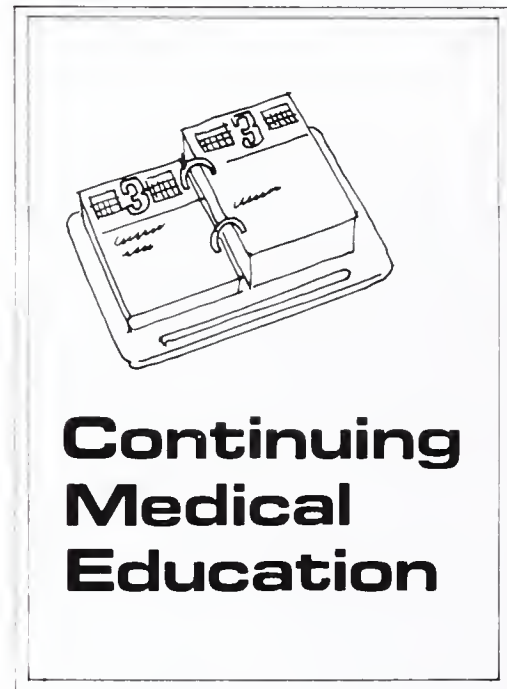
The process of initiating such a "201 File," as the Army had it, is probably simple — the drug companies might benefit by life-long advertising therein. However, its preservation and maintenance by the individual might be a horrible problem. "Where's his 201 file?" asks the desperate interne as he helps wheel into the ER the comatose elderly drunk.

If the cumulative effect of radiation is the same as just one big overdose; if the mother's sin of ingesting DES to save her threatened abortion is visited on her pubertal daughter in the form of

vaginal cancer; then maybe the medical profession should consider the matter of the permanent medical history file for the patient to keep rather seriously.

After all, we do now have computerized memory banks which can condense a large amount of vital statistical medical history, more than the old Family Bible ever could!

J.I.F.R.



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Mabel Smyth Bldg. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 521-5064.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.

7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

(Contact CME Dept. for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
- Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
- Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
- Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

St. Francis Hospital

1. Medical Grand Rounds, Tuesday (4th & 5th) 12:30-1:30 p.m. Sull. IV Classroom
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
7. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Honolulu County Medical Society and Local Hospitals, Honolulu

Type: 1, 1 hr/day, 1 day/mo from 12 mos

Fee: None Methods: AV, O, Pan

Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

Type: 1, 1 hr/day, 1 day/mo for 8 mos

Fee: None Methods: AV, Clin C, O, Pan, R

Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

Apr. 3-8, 1977 "Special Seminar on Trauma"—7:30 a.m.-1:00 p.m. Mon. thru Fri., Sheraton Waikiki Hotel, Honolulu. Pan-Pacific. Cat. 1. Pan-Pacific Members \$200, non-members \$250. Contact: John R. Watson, M.D. 536-4911.

Apr. 4-9, 1977 Adolescent Medicine—Unv. of HI Schl. of Med., Dept. of Pediatrics, 226 N. Kuakini St., Hono., 96817. Held at 1319 Punahou St. Hono., 96814. Fee \$40.

Apr. 5, 1977 "Gastrointestinal Cancer: Current Status of Treatment of Advanced Diseases & Chemotherapy" Tues. 12:30 p.m. Wahiawa Hsp. 1 hr. Cat. 1. Speaker: Joseph R. Bertino, M.D. Contact: Norberto Baysa, M.D.-Wahiawa Hsp. for further info.

Apr. 9, 1977 "Asthma-Planning for Diag., Treatment & Patient Education"—Kaiser Hsp. Kaiser Pac. Aud. Sat. 7:30 a.m. Speaker: Alexander Roth, M.D. 1 hr. Cat. 1 (Contact CME Dept. Kaiser for further info)

Apr. 12, 1977 "Mucocutaneous Lymphnode Syndrome: Diagnosis & Management." Tues. 12:30 p.m. Wahiawa Hsp. 1 hr. Cat. 1. Speaker: Richard Mitsunaga, M.D. Contact: Norberto Baysa, Wahiawa Hsp. for further info.

Apr. 16, 1977 "Diagnostic Entomology"—Sat. 7:30 a.m. Kaiser Pac. Aud. Kaiser Hsp. Speakers: A.G. Scottolini, M.D., N. Bhagavan, Ph.D. Contact: CME Dept. Kaiser for further info.

Apr. 16-23, 1977 Emergency Medicine—Unv. of So. Calif. Schl. of Med. 2025 Zonal Ave. Los Ang. 90033. Held at Kona Surf Hotel, Kona, HI. Gail Anderson, M.D. Prof. of Emergency Med.

Apr. 19, 1977 "Sex Abuse Victims-Adults & Children"—Tues. 12:30 p.m. Wahiawa Hsp. 1 hr. Cat. 1. Speakers: Drs. Francis Terada & Geo. Starbuck. Contact: Norberto Baysa, CME-Wahiawa Hsp. for further info.

Apr. 17-30, 1977 Visiting Professor of Oncology, Am. Cancer Soc.-HI Div. Inc. 200 N. Vineyard Blvd., Honolulu 96817. 10 days 40 hrs. No fee. Ph. (808) 531-1662 for further info.

Apr. 23, 1977 "Chronic Complications of Adult Onset Diabetes"—Sat. 7:30 a.m. 1 hr. Cat. 1. Kaiser Pac. Aud. Kaiser Hsp. NCME Videotape. Contact: CME Dept. Kaiser for further info.

Apr. 26, 1977 "Rheumatoid & Other Collagen Disease of Children"—Tues. 12:30 p.m. Wahiawa Hsp. 1 hr. Cat. 1. Speaker: Raquel Hicks, M.D. Contact: Norberto Baysa, CME Wahiawa Hsp. for further info.

Apr. 30, 1977 "Basic Concepts in the Management of Diverticulitis of the Sigmoid"—Sat. 7:30 a.m. 1 hr. Cat. 1. Kaiser Pac. Aud., Kaiser Hsp. Speaker: William Longmire, M.D. Contact: CME Dept. Kaiser Hsp. for further info.

Apr. 30, June 7, 1977 Management of the Surgical Patient. Stanford Unv. Schl. of Med. Stanford, CA 94305. Held at Mauna Kea Beach Htl. Kamuela 96743. 7 days 27 hrs. Fee \$275.

- May 1-7, 1977 Radiology-Univ. of So. Cal. Schl. of Med. 2025 Zonal Ave. LA 90033. Held: Maui Surf Htl. Maui. 5 days 30 hrs.
- May 7-14, 1977 Diagnostic & Therapeutic Skills-Univ. of So. Cal. Schl. of Med. 2025 Zonal Ave. LA 90033. Held: Mauna Kea Htl. Kamuela, HI. 5 days.
- May 7, 1977 "Multi-Disciplinary Team Approach to Cancer Health Care"-Sat. 7:30 a.m. 1 hr. Cat. 1. Kaiser Pac. Aud.-Kaiser Hsp. Hospital Cancer Team. Contact: CME Dept. Kaiser for further info.
- May 14, 1977 "Thyroid Function"-Sat. 7:30 a.m. 1 hr. Cat. 1. Kaiser Pac. Aud. Kaiser Hsp. Univ. of HI John A. Burns Schl. of Med. Contact: CME Dept. Kaiser for further info.
- May 14-21, 1977 Orthopedic Review-Univ. So. Cal. Schl. of Med. 2025 Zonal Ave. LA 90033. Held: Royal Lahaina Htl., Maui. 25 hrs. Faculty: J. Paul Harvey, Jr., M.D. Dept. of Orthopedics-U of SC.
- May 21, 1977 "Newer Developments in the Treatment of Peptic Ulcer Disease"-Sat. 7:30 a.m. Kaiser Pac. Aud.-Kaiser Hsp. 1 hr. Cat. 1. Speaker: Myron Lezak, M.D. Contact: CME Dept. Kaiser for further info.
- May 28, 1977 "Toward More Complete and Effective Pre-Operative Patient Education."-Sat. 7:30 a.m. Kaiser Pac. Aud.-Kaiser Hsp. 1 hr. Cat. 1. Speaker: Ronald Pion, M.D. Contact: CME Dept. Kaiser for further info.
- May 26-30, 1977 Patient-Oriented Applied Med. Advances-Univ. of So. Cal. Extended Programs in Med. Educ. 3rd & Parnassus Aves. San Fran. 94143. Held: Mauna Kea Htl. Kamuela, HI. 5 days-30 hrs.
- June 11-18, 1977 Orthopedic Review-Univ. of So. Cal. Schl. of Med. 2025 Zonal Ave., LA 90033. Held: Mauna Kea Beach Htl. Kamuela, HI. 5 days-30 hrs.
- June 18-25, 1977 Lab Management for Pathologists-Univ. of So. Cal. Schl. of Med. 2025 Zonal Ave., LA 90033. Held: Mauna Kea Beach Htl. Kamuela, HI. 5 days-30 hrs.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1976 Supplement to JAMA or call the HMA Office.



Charles Conloy Ching, M.D.

1481 South King Street
Honolulu, Hawaii 96814

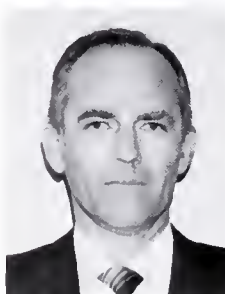
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Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

New Members—Two have joined from the Kaiser Permanente Group: **Carlo Brizzolara MD** as a Practicing Affiliate member; **James A. Koch MD**, a transfer from New Mexico, as an Active member, a Fellow and ABFP (1972), and Ass't Director of the Family Practice Residency Program at Kaiser and at the UHSM. We welcome you both!

News of Members—**Jim Fleming** of Maui has been granted Inactive status; he still practices occasionally. **Ernesto Santos** has become a Fellow.

AAFP State Officers Conference—on 23 and 24 April in Kansas City will have as Hawaii representatives our Secretary **Pat Dietrich** and Delegate **Felix Lafferty**.

Condolences—to **Dr. & Mrs. Kenneth Kern** for the loss of their infant daughter Coleen on 20 February.

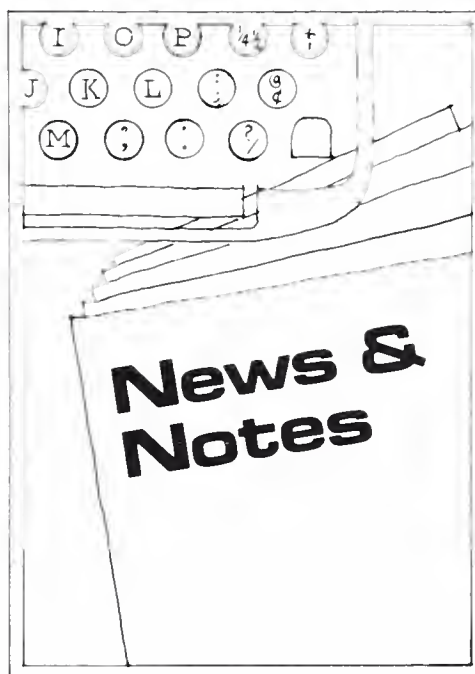
Act 219 Hearing—before the House Consumer Protection Committee was graced by the presence of some 25 physicians as a show of interest and force that must have been a bit impressive to the Committee. HAFP members present included **Pat Dietrich**, **Mike Hase**, **Tom Cahill**, **Helen Percy** from Maui, **Fred Reppun** and **Pat Walsh**. Members of the HMA Ad Hoc Committee on 219 presented testimony.

Council Meeting—on 17 February, the Council voted to accept the offer from **Thomas Stern MD**, Sec'y of the AAFP Commission on Education, to put on a Symposium on Teaching Skills in Family Practice

in conjunction with our annual meeting the weekend of 21 January 1978 at the Kaiser Foundation Hospital.

CME—Don't forget the Pan Pacific Surgical Ass'n "Special Seminar on Trauma" 3-8 April at the Sheraton Waikiki; the Minnesota AFP Annual Spring Refresher 13-14 April in Bloomington, Minn.; and the Alaska AFP first annual "Midnight Sun Medical Seminar" 3-14 June in Anchorage.

Next Dinner Meeting—At the Reppun's in Kahalu'u will feature Waiahole Prime Ag-rib and Waikane Pao Pau. Guest speakers will be **Kenneth Livingston MD** of Toronto, Ontario on "Pain" (he is a neurosurgeon) and **Lynette Paglinawan** on "Ho'oponopono" (she was formerly with the Liliuokalani Trust as social worker).



HENRY N. YOKOYAMA, M.D.

Professional Moves

The Year of the Snake has descended upon us accompanied by weeks of blustery weather and this much appreciated rain . . . but enough is enough!

In January, dermatologist **Francis J. Dann** joined the Fronk Clinic at 839 So Beretania; GP **Glenn Stahl** relocated to the Kaneohe Business and Professional Center at 46-005 Kowa St, Kaneohe; and **Richard Chun** relocated to the Professional Center Bldg at 1481 So King St. The Hawaii Permanente Medical Group added to its ranks GP **James A. Koch**

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and internist-nephrologist **David Yuan. Norbert B. Wong** joined the Emergency Group, Queen's Medical Center. On Maui, GP **John Newman** associated with **Donald Altfeld** at the Lahaina Square, Lahaina.

So, on to February . . . We notice that in Feb, the Hawaii Permanente Medical Group became the Kaiser-Permanente Medical Care Program. GP **Robert Fyrberg** joined its 1697 Ala Moana Blvd group while GP **Hatim Kanaaneh** joined its Kaneohe Clinic at 45-602 Kam Hwy . . . Nephrologists **Arnold W. Siemson, Eugene G.C. Wong** and **Jared G. Sugihara** left Straub and formed The Nephrology Associates, Inc with temporary offices at Harkness Pavilion, QMC. Endocrinologist **Werner G. Schroffner** left Fronk Clinic and moved across the street to Suite 315, Medical Dental Plaza at 848 So Beretania St. Neurologist **Robert Bart** is leaving the Rehab Center to go into private practice and pediatrician **Michael Crowley** is the new associate medical director. On Kauai, the Kauai Medical Group announced that **James Hansen** will be handling emergency medicine at the Lihue Clinic while on the Big Island, **E.A. Haunz** (specializing in diabetes and related diseases) joined the Kona Coast Medical Group Inc in Kailua-Kona . . .

Bulletin

Ed Kagihara announced that the Annual KCH Benefit Show will be on Saturday May 7 at the Pacific Ball Room, Ilikai. Featured will be a delightful show produced by Ed, a mixed chorus of Kauikeolani Keiki Singers and the Floating Ribs. Band leader **George Takushi** will provide the music for the show and the dance with his "Torchers".

Hors de Combat

In January, DSSH director Andrew Chang not only released the names of physicians and dentists earning more than \$100,000 from Medicaid in 1976 and also those earning more than \$80,000 . . . Chang reported that in 1975, whereas only 19 physicians had earned more than \$30,000 from Medicaid, in 1976, there were 98 physicians and 56 dentists. Chang estimates a \$8.5 million deficit by the end of the fiscal year in June and blames the deficit on general increases in health care costs, increases in the Medicaid reimbursement rate for physicians as authorized by the 1975 Legislature and on increased case loads with more than 87,300 Island residents now receiving Medicaid benefits . . .

Whereupon our champion, HMA prexy **Cal Sia** wrote Andrew Chang: "I am very disturbed and shocked at the recent release of a report by your department officials on the income of doctors in the Medicaid program to the newspapers . . . Physician fees are *not* the major factor for the rising cost of the Medicaid tab . . . The bulk of the rising Medicaid costs fall in the area of hospitals, dentists, Xray and lab fees and not physician fees . . . To name a few doctors who have performed services and earned such and such income serves no function or purpose . . . The State has the responsibility to release figures telling how much the doctors earned from Medicaid only if there is a point to be served, ie, if there truly is Medicaid abuse by these physicians . . ."

Miscellany

The impatient teenager was beefing because he had to wait in the line so long for confession: "They should be more efficient . . . They ought to have a fastlane for those with three sins or less . . ."

The same teenager: "Father, forgive me, for I kissed a pretty girl."

Priest: "How many times did you commit this terrible sin?"

Teenager: "Father, I came to confess, not to brag . . ."

Father O'Malley who was developing presbycusis of late called in one of the sisters for a chat . . . "What would you have been if you hadn't become a nun?" he asked . . . "A prostitute," replied the sister. The father sat stunned in his chair . . . On regaining his composure, he repeated the question . . . "A prostitute," answered the nun again . . . "Oh, thank the good Lord," sighed the priest with relief, "I thought you said a Protestant."

(Contributed by "Anonymous")

Life In These Parts . . .

The 40 year old married woman with 12 and 14 year old children was having her first pelvic exam in 12 years . . . We asked routinely, "Do you take the pill?" and were surprised when she replied spontaneously, "No, I take chances . . ."

Our Hawaii Medical Library is the only library in the State that permits smoking . . . The reason is that it is not a state facility like the other libraries . . .

The St. Francis Hospital Home Care Program received a Federal grant to develop the Kauai Home Health Service which commenced operations on Feb 1 this year and has offices at the Wilcox Memorial . . .

The Senate Health Committee was informed that failure to appropriate \$1.3 million for 1978 and \$1.4 million for 1979 for existing alcohol and drug abuse programs would result in the loss of an estimated \$3.8 million in matching Federal funds . . .

A San Francisco doctor's widow wrote "Dear Abby" about how her husband died at 61, having literally worked himself to death with house calls day and night . . . When this dedicated man died, his patients all wailed and groaned, "What will we ever do without our dear doctor?" But 2 years later, their combined unpaid bills totaled \$11,000 etc, etc . . . Dear Abby commented, "Dear Widow R: It brings to mind an ancient proverb: 'The wise dentist collects the fee while his patient's tooth is still aching.'"

The HMA, the Hawaii Nurses Association and the State Commission on Aging told state legislators that they feel that persons who want to "die with dignity" can do so without legislation . . . **J.K. Sims** testified against "living wills," contending that a physician's philosophy is to heal patients, not to let them die and that the term "terminal condition" cannot be defined. "It is a very very difficult decision for a physician to withdraw or withhold a therapeutic modality and subsequently witness the deterioration of a person or a patient . . . It is difficult enough to witness this deterioration while actively treating the patient . . ."

Paraquat, a defoliant produced by Standard Oil Co has reportedly caused five human deaths in the Kona area alone . . . Bill Raiser, a Kona resident, has done research for about a year and claims that at least 30 animals have died in the Kona area alone and over 200 cases of diagnosed Paraquat animal poisoning on the Big Island and on Maui. Raiser would like to see Paraquat taken off the market, or have the company come out with a true antidote . . . (or even mixed with a laxative so that it can't be held in the human system).

A David Rodwell wrote: "I warmly applaud President Carter's move to conserve energy by lowering the thermostat to 65° . . . It is my belief that this should be done throughout the U.S. and instituted in the State of Hawaii as soon as possible. I have instructed the maintenance man in my office to lower the thermostat to 65°. I feel that if other businesses would follow my example, considerable energy might be saved." (Ed: We don't deny 65° may be a good idea elsewhere, but not in Hawaii where it will *require* energy to run our air conditioners to lower our prevailing mid 70's temp to 65°. Besides, our poor patients in their flimsy examining gowns may freeze to death . . .)

In February, when negotiations for longer contracts and higher pay broke down, 35 psychiatrists with the State Health Department diagnosed themselves sick and stayed home for 2 days . . . leaving only 7 psychiatrists on duty in the State . . . Health director George Yuen forthwith termed the "sick out" a "concerted illegal act in violation of anti-strike provisions in the bargaining agreement" and docked their pay for 2 days . . .

In January, director George Yuen had dissolved the doctors staff organization at the controversial Kona Hospital which has been embroiled in constant controversy involving staff doctors, the County and the State since 1975. Then in February, George restructured the staff so that voting rights were denied to nearly ½ the doctors who had previously voted . . . OB man **Allan Hubacker** charged that the State's move was "unilateral and arbitrary." (Hubacker and 5 other doctors had filed suit challenging the appointment of Kenji Nagao as administrator, but had dropped the action earlier in an effort to smooth over ruffled relations with the Health

Dept.) The latest dispute started when **Gunars Medins** was elected chief of staff in a compromise effort among the factions in the staff. **Jim Mayer**, former vice chief of staff and a leading dissident was downgraded to courtesy staff and denied voting rights . . . The Health Dept. officials were declining comment on the move . . .

Laetrile Bill? In the wake of heavy opposition from the medical community, the House Health Committee deferred action on a House bill introduced by a Committee for Freedom of Choice of Cancer Therapy . . . A Bob Anderson, chairman of the committee and a nutritionist columnist had sent copies of the already passed Alaska Bill to all state legislators. Bob is the president of the American Opinion Book Store, an educational arm of the John Birch Society . . .

(Ad in the Dec 9, 1976 issue of the Honolulu Star Bulletin)
"Public Apology—In May of 1975, I filed a civil action against Dr. **Ruben Casile** claiming that he had negligently treated me. I now realize that Dr. Casile was in no way negligent in his treatment of me and wish to take this opportunity to publicly apologize to Dr. Casile. If I have caused any embarrassment or have in anyway damaged his reputation in the community as a medical doctor, I am sincerely sorry. I have caused the complaint which was filed against Dr. Casile to be dismissed. Dated at Hilo, Hawaii, Nov 9, 1976. Thelma K. Santos" (Pau Hu Hu, eh?)

A Star Bulletin article headlined, "Isle Medical Costs Among Highest" blames unnecessary duplication and interhospital competition as a major underlying cost booster. "Some assessors of the medical scene" say that there are 7 independently operated hospitals in Honolulu within driving or walking distance of each other and if these institutions were serious about cutting costs, they would consolidate into three hospitals. The writer takes to task the State Health Planning and Development Agency which recently authorized total body scanners (at \$750,000 each) for St. Francis and Children's hospitals, but turned down the request by Queen's Medical Center which already has a head scanner (and therefore the logical choice?)

Visiting Physicians

In Feb, endocrinologist professor **Jerome Grunt** was visiting KCH from Children's Hospital, Kansas City, Mo. Jerome with receding forehead, accenting furrowed brows, curly hair trimmed short, and dark rimmed glasses and suit to reinforce his professional profile lectured to capacity crowds attracted by his well organized lectures. Jerome would stop for questions and won our hearts with the apology, "My colleagues often accuse me of oral diarrhea." We learned that:

Growth hormones are messengers, species specific, complex amino acids and immunologically capable, but not biologically capable . . . Growth hormones are controlled by GH releasing factor and GH inhibiting factors . . . GH releasing factors are influenced by vasopressors, L-Dopa, stress, etc, while GH inhibiting factors are affected by increase in glucagon and decrease in insulin . . . Factors stimulating GH include stress, estrogen, protein, sleep, fasting, exercise, Arginine, Dopamine etc . . .

Hypertension expert **Ray Gifford** was visiting U of H professor for a week. Bespectacled, stout with early vertex alopecia, and dressed casually in Aloha shirt, Ray was one of the most interesting speakers in these parts in a long while and speaking on a practical subject. Herein are a few gems:

Interesting side effect of guanethadine: erection without ejaculation . . .

Diuretic induced hypokalemia is not harmful unless the patient is on digitalis . . .

Oral diuretics reduce plasma volume whereas other antihypertensive agents (with the exception of propranolol raise PV . . . Therefore imperative that oral diuretics be used with other antihypertensive agents . . .

What diuretic? Spironolactone has no advantage over the thiazides . . .

The Renin story: All sympathetic blockers reduce renin activity . . .
All diuretics and vasodilators increase renin activity . . .

Marks says more people are living on renin than dying from renin activity (re availability of research funds for renin study) . . . We cannot correlate changes in renin activity with BP drop in studies with propranolol or thiazides . . . Renin activity does not help in treating patients . . .

Propranolol and renin: In low doses propranolol suppresses renin, but have no effect on BP . . . In larger doses propranolol will reduce BP . . .

Evaluation of hypertension: a) Every patient should have a history, physical and repeated BP determinations: CBC, UA, chest Xray, SMA-12 (cholesterol, glucose, serum K, BUN or creatinine) and triglycerides (for patients less than 50 years of age, after age 60, there is little correlation of BP with lipids) b) Patients need IVP if younger than 30 with a diastolic greater than 110; if diastolic is greater than 130 at any age, or have systolic or diastolic bruits in their epigastrium, or have accelerated hypertension, resistant hypertension or urologic indications . . .

Ocular complications: The eye rarely suffers from hypertension, but the Keith-Wagener-Barker classification is useful for prognosis: Group I—45.8% 20 year survival; Group II—21.3% 20 year survival; Group III 30% 5 year survival; Group IV—10% 5 year survival.

Diagnoses in 4,939 patients referred to Cleveland Clinic 1966-67

Essential hypertension	88.9%
Chronic glomerulonephritis	5.2%
Renal vascular Disease	4.4%
(Surgically treated	1.4%)
Coarctation Aorta	0.6%
Primary Aldosteronism	0.4%
Cushings Syndrome	0.3%
Pheochromocytoma	0.2%

EKG and Cardiac Complications of Hypertension

Lead 1 Broader notched p wave
QRS voltage increase
ST-T wave changes
Infarction changes

Management of Hypertension a/c Acute Intracranial Hemorrhage

Sodium nitroprusside drip over 1 hour to see if patient improves

Avoid Reserpine, Methyl Dopa, Diazoxide

Emergency Treatment Hypertension a/c Acute Left Ventricular Failure

1. Diuretic: Furosemide 40-80 mg IV or Ethacrinic 50-100mg IV
2. Antihypertensive Agent: Sodium Nitroprusside 150mg /L IV infusion or Diazoxide 300mg IV bolus
3. Cedilanid IV (not always necessary)
4. O₂, MS and rotating tourniquet (rarely necessary)
5. Sodium restriction

"Porogee" Jokes (By Alan Luning)

A "Porogee" lady sez to me, "You know why they paint 'The Bus' on the city buses?" I sez I dunno . . . She sez, "So the Porogee's would stop waiting for the garbage trucks . . ."

Do you know why the Porogee's seldom have hemorrhoids? Because God made them perfect asses . . .

Conference Notes

In the wake of two recent cases of delayed diagnoses of ruptured abdominal aortic aneurysms at Kuakini (one was a typical low back syndrome and the other a right renal colic) the Surgical Department invited Straub vascular surgeon **Robert Kistner** to discuss abdominal aortic aneurysms, their early diagnosis and management . . . Herein are notes therefrom:

Mortality of AAA: Surgical-80% 2 year survival vs non-surgical 45% survival

Symptomatic AAA: Pain, abdomen, back and flank; palpable aneurysm

Ruptured AAA: Pain, syncope/hypotension, palpable aneurysm

Book Reviews



Current Medical Diagnosis and Treatment, Marcus A. Krupp and Milton J. Chatton, Los Altos, Calif., Lange, 1977. 1,066 pages. Price: \$16.00.

Best bargain for almost any specialist, especially if he sometimes copes with problems outside his specialty! Some of the chapters are perhaps a little more authoritative than others, but none can be faulted on this ground. Rees on skin diseases, and Jawetz and Grossman on infectious diseases and anti-infective agents, are especially well done.

The chapter on endocrine disorders needs to have the portion dealing with steroid therapy completely rewritten; it sounds as if it had not been changed since about 1965. "Bleeding tendency" is too vague a reference to aggravation of senile purpura of the arms, and the connection between steroid therapy and peptic ulcer, if any, is by no means as direct and specific as the author states. Virtually no reference is made to the important fact that the side effects of systemic steroids are almost all dose dependent, and that the effects produced by hydrocortisone are not at all those to be expected with prednisone, much less triamcinolone, with a few exceptions of course.

On the whole, the book is the same excellent, authoritative, up-to-date volume we've learned to expect from these editors and this publisher. No primary care physician can really afford not to have it handy.

HARRY L. ARNOLD, JR., M.D.

NEWS & NOTES *continued*

Evaluation of AAA: Size: Palpation, Xrays lateral or oblique; ECHO

Management: Greater than 7.0 cm: immediate surgery
5.0 to 7.0 cm: early surgery
Less than 5.0 cm: Mortality same whether surgical or non-surgical management

Russel Hicks spoke on Substance Abuse at KCH Monday noon conference . . . Russel warned of the new drug Phencyclidine (PCP) sold as THC, April Dust, etc . . . which is sniffed or smoked, is a hallucinogen causing delirium and semi-comatose states . . . Diagnostic sign is a resting nystagmus.

Clues for diagnosing street drugs: High BP—Amphetamines; High pulse—hallucinogens and stimulants; depressed respiration—barbiturates, opium, tranquilizers; depressed sensorium—barbiturates, etc; acne—amphetamine, LSD; resting nystagmus—PCP; Pupils—fixed and constricted with opiates; normal with alcohol, marijuana, barbiturates; dilated

with large doses of amphetamine; non-reactive with amphetamine; reactive to light with LSD . . .

Management of comatose patients: Dd diabetic coma . . . Lavage if before 48 hours . . . If picture not clear—observe . . . Do not lavage when patient is agitated or suspected of ingesting a hallucinogen . . . Avoid drugs to treat drug abuse ie, except when the patient is on a bad trip; then use Valium 20mg IM rather than Thorazine . . .

At the Kuakini quarterly meeting, cardiac surgeon **Richard Mamiya** showed part of his Beck & Beck film on "Coronary Bypass" which was shown at the American Surgical Academy meeting 2 years ago . . . For once the majority of the staff remained after the mandatory business portion without walking out en masse to the annoyance of the guest speakers . . . As **Akira Kutsunai** sitting next to us put it: "It strikes quite close to home . . ." (Meaning we as physicians all realize we are all coronary prone . . .) Dick showed us his own incredible statistics for 1975 and 1976:

No. of Grafts	1975	Mortality	1976	Mortality
1	17		9	
2	34		22	
3	52		70	
4	33	4	72	
5	6		53	
6	3		23	
7	1		5	
8			4	
9			1	

Total 1975 patients 146; total 1976 patients 259

Grant total for 1975 and 1976 405 patients with 4 deaths or less than 1% mortality

Statistics on 206 patients with 4 or more by pass grafts:

Postop Complications:		
Bleeding		19
Perioperative Infarct		10
Renal failure		2
Postpericardiectomy Synd		2
Mediastinal Infection		1
Hepatitis		1
Late Complications: Death		1
Graft closure		2
MI		0

Clinical Results:		
Asymptomatic		80%
Improved		10%
Unimproved		10%

When coronary arteriography shows 2 or 3 artery disease, surgery indicated Saphenous vein by pass indicated when arteriography shows 70% occlusion By pass even with less than 1mm vessels . . .

Our "Angels"

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The postsurgical patient

Potent pain relief without aspirin complications.



TYLENOL[®] with Codeine[®] tablets/elixir

Tablets Contain codeine phosphate* No 1 — 7.5 mg (1/8 gr), No 2 — 15 mg (1/4 gr), No 3 — 30 mg (1/2 gr), No 4 — 60 mg (1 gr) — plus acetaminophen 300 mg
Elixir Each 5 ml contains 12 mg codeine phosphate* plus 120 mg acetaminophen (Alcohol 7%) *Warning: May be habit forming

The leading oral narcotic-containing combination without A.P.C.

Contraindications: Hypersensitivity to acetaminophen or codeine

Warnings: Drug dependence. Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to other oral narcotics. Subject to the Federal Controlled Substances Act. Usage in ambulatory patients. Caution patients that codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery. Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) with this drug may exhibit additive CNS depression. When such a combination is contemplated, reduce the dose of one or both agents.

Usage in pregnancy. Safe use not established. Should not be used in pregnant women unless potential benefits outweigh possible hazards.

Precautions: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce

adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions. Codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to certain patients such as the elderly or debilitated and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequent, lightheadedness, dizziness, sedation, nausea and vomiting, more prominent in ambulatory than nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Others, euphoria, dysphoria, constipation and pruritus.

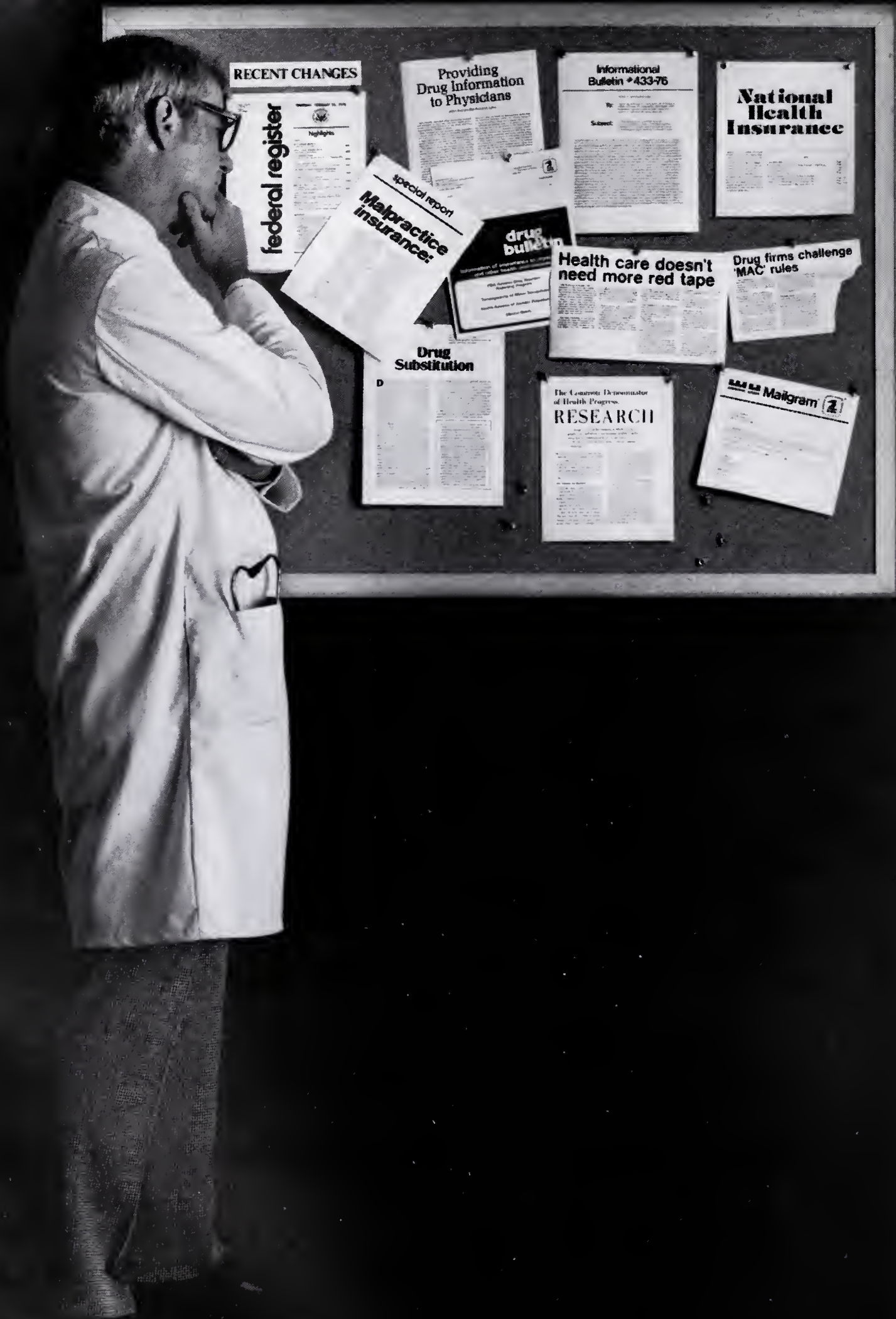
Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For information on symptoms and treatment of overdosage, see full prescribing information.

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RECENT CHANGES

federal register

Providing Drug Information to Physicians

Informational Bulletin #433-76

National Health Insurance

special report Malpractice insurance

drug bulletin

Health care doesn't need more red tape

Drug firms challenge 'MAC' rules

Drug Substitution

The Contradictory Demonstration of Health Progress RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original FDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



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Hawaii Medical Service Association

APRIL 1977
VOL. 36, NO. 4

Hawaii Medical Journal

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Valium (diazepam) is a benzodiazepine with a character all its own.

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But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium[®] (diazepam)[Ⓢ]

2-mg, 5-mg, 10-mg scored tablets
**a prudent choice in psychic
tension and anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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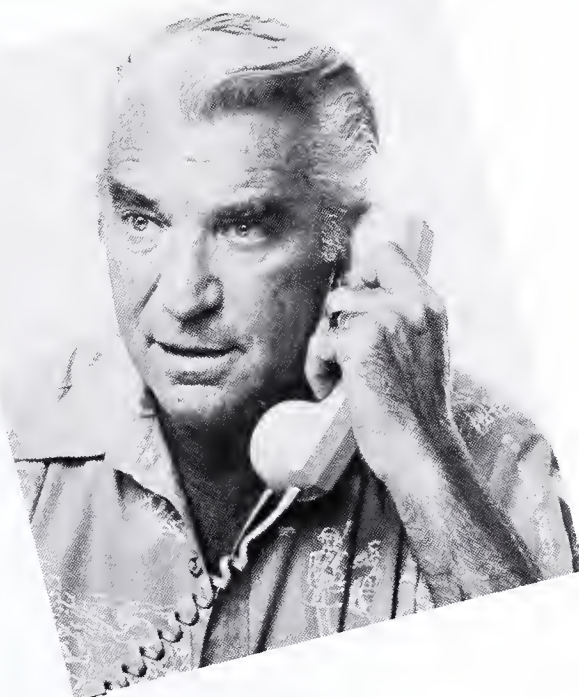
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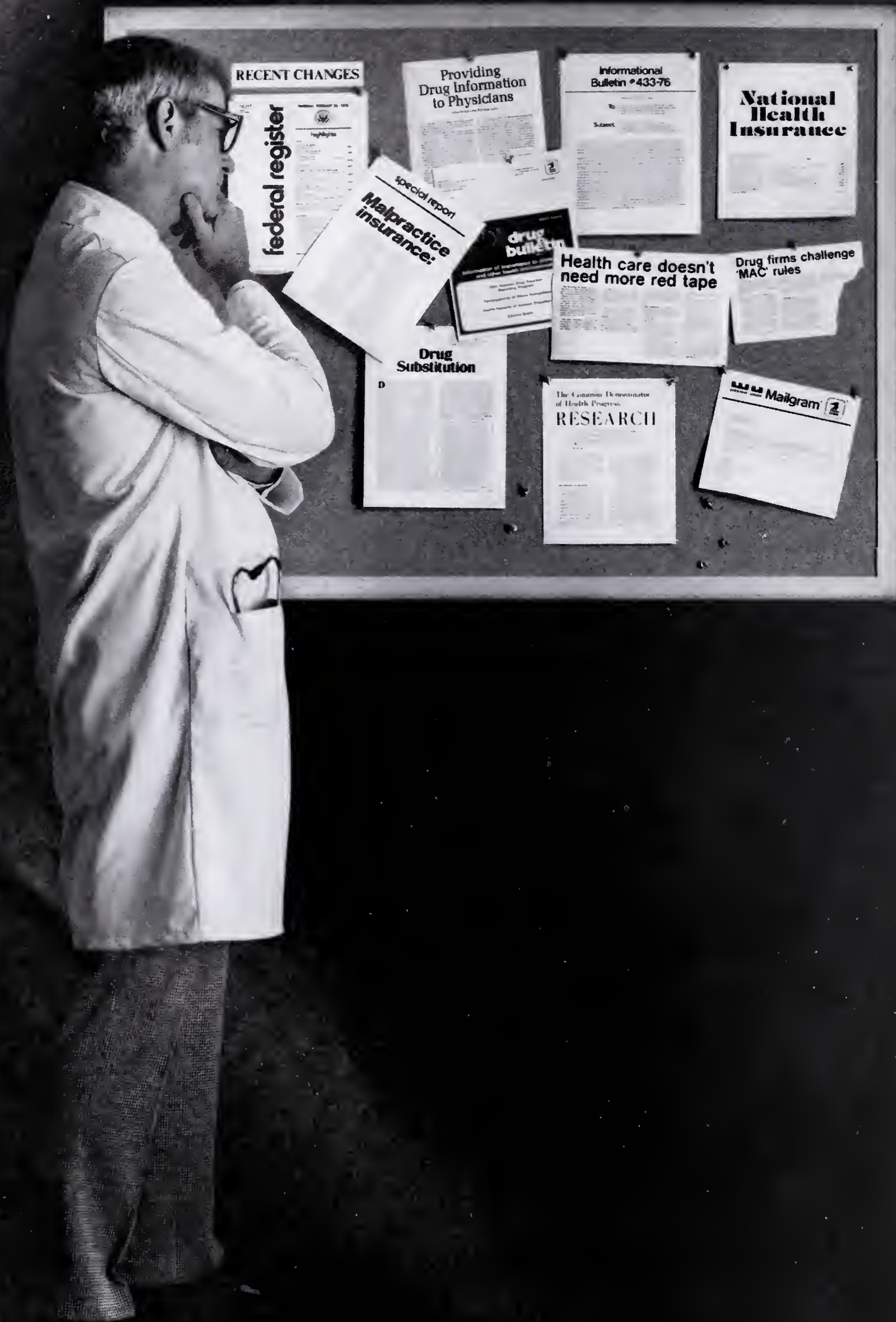
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**Monday
October
1977**

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RECENT CHANGES

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**Providing
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**Informational
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**National
Health
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**special report
Malpractice
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**Health care doesn't
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**Drug firms challenge
MAC rules**

**Drug
Substitution**

**The Common Denominator
of Health Progress
RESEARCH**

Mailgram

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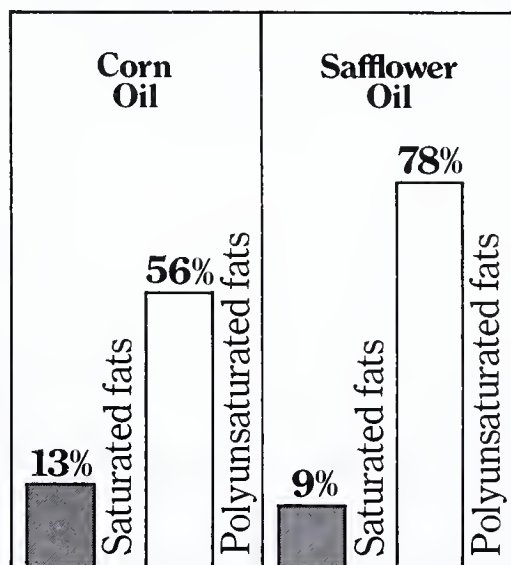


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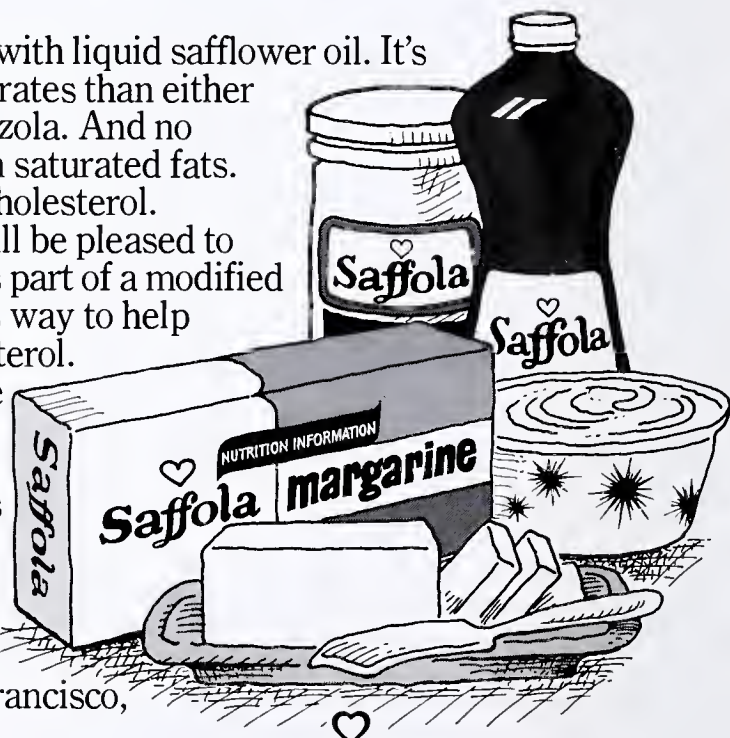


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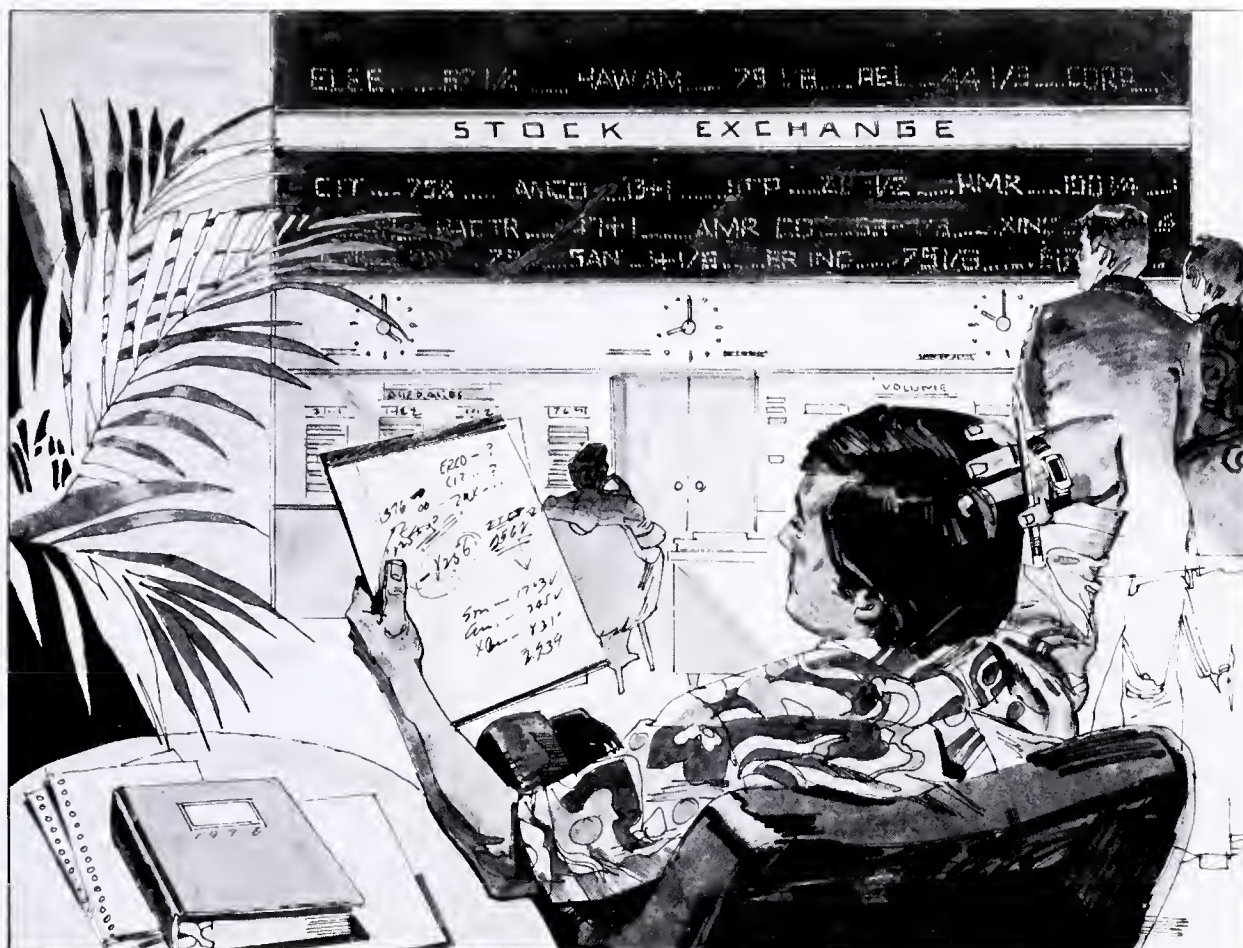


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Non-gonococcal urethritis in Hawaii

TIM KUBERSKI, M.D.*, SAM PERRY, M.P.H.**, ROY OHYE, M.S.†, and
NED WIEBENGA, M.D., M.P.H.††, Honolulu

● *Non-gonococcal urethritis (NGU) currently accounts for about 75% of all the urethritis seen in men attending the Hawaii State Venereal Disease (VD) Clinic. A study group of 26 consecutive male VD clinic patients with NGU were examined for various possible etiologic agents. From urethral cultures, Chlamydia trachomatis was recovered from eleven patients (42%); Trichomonas vaginalis, Herpesvirus hominis and Neisseria gonorrhoeae from one patient each. Epidemiologic data were retrospectively reviewed from 109 patients with NGU and 107 gonorrhea patients, to find any differences between the two forms of urethritis. The significant differences observed were: NGU patients tended to be older, Caucasian, have a longer duration of symptoms before coming to the VD clinic and engage in sexual intercourse despite symptoms more frequently. The prevalence of complement-fixing antibody to a chlamydia group antigen and Herpesvirus were found to be significantly higher in the VD clinic patients over a control population.*

The sexually transmitted diseases are currently a significant medical and public health problem.¹ The magnitude of this problem is reflected by the rapid rise of gonorrhea to the most commonly reported infectious disease in the United States.²

In men, gonococcal urethritis is a well-defined syndrome clinically and etiologically, and provides the basis for a simple classification of urethritis in males by grouping into gonococcal and non-gonococcal (NGU) forms. A distinction be-

tween these two types of urethritis has become necessary because of the increasingly frequent observation that patients clinically thought to have gonococcal urethritis subsequently are found not to have gonorrhea.

The increase in gonorrhea has apparently been associated with the occurrence of sizable numbers of a less well-defined form of urethritis, currently termed non-gonococcal urethritis (NGU). The true incidence of NGU, also referred to as non-specific urethritis (NSU), is not known because it is not a reportable disease in the United States; therefore, important aspects of this form of urethritis have not been well characterized.

In Great Britain, where information on patients with NGU has been recorded, this is the most frequently reported sexually transmitted disease.³ There is suggestive evidence this may also be true in the United States.^{2,4}

Before adequate efforts for control or therapy can be implemented, a better definition of the etiology, epidemiology and various clinical aspects of this disease (or diseases) needs to be made. As will be illustrated, NGU is a common diagnostic problem at the Hawaii State Venereal Disease clinic.

Materials and Methods

STUDY POPULATION

A series of 26 consecutive male patients presenting with urethritis (defined as the presence of a urethral discharge and/or dysuria) to the Kapahulu Venereal Disease (VD) Clinic during November 1974 will be referred to as the study group. Men with signs or symptoms of urethritis were classified presumptively as having NGU when no organisms consistent with *Neisseria gonorrhoeae* were demonstrated on a Gram-stained smear of their urethral scrapings. Patients were excluded from the study if any form of antibiotics had been taken in the two weeks prior to the clinic visit. All patients were given a

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pertinent physical examination and interviewed by one of us (T.K.), using a standard questionnaire pertaining to clinical and venereal disease history. Evaluation of the urethral exudate was similar to that described by Jacobs and Kraus.² The patients were given therapy at the discretion of the clinic physician after the appropriate specimens had been obtained.

COLLECTION OF SPECIMENS

A series of three calcium alginate-tipped urethro-genital swabs (Calgi-swabs, Inolex Corp.) were passed 2-5 cm into the urethra, each swab being passed approximately 1 cm further into the urethra than the preceding one. A smear for Gram stain and bacterial cultures were prepared from the first swab. The second swab was inoculated into 2 ml of a transport media (0.2 M sucrose in 0.02 M phosphate buffer, pH 7.0 containing gentamicin and mycostatin) for chlamydia and virus isolation. The third swab was inoculated directly into Trichosel broth (BBL, Cockeysville, MD 21030) for the isolation of *Trichomonas vaginalis*. In the absence of a urethral discharge, a prostatic massage was performed and any expressible prostatic secretions were cultured for *T. vaginalis* by inoculation into Trichosel broth and bacterial cultures. Blood specimens were routinely collected for serologic testing during the initial visit to this clinic.

LABORATORY METHODS

Thayer-Martin and 10% sheep blood agar plates were inoculated with the first swab. The plates were immediately placed in 5-10% CO₂ atmosphere and incubated at 37° C. *N. gonorrhoeae* was identified using conventional methods.⁵ Bacteria recovered on the blood agar plate were characterized according to their Gram stain reaction. Organisms morphologically resembling *Corynebacterium vaginale* were evaluated for identification purposes following the methods of Dunkelberg, et al.⁶ On the day of collection, material for virus isolation was inoculated into a tissue culture tube containing a monolayer of W1-38 cells. Material for chlamydial isolation was frozen at -70° C until tested. The W1-38 cells were maintained a minimum of three weeks after inoculation and discarded if no evidence of a cytopathic effect developed. Chlamydia isolation techniques, using cultures of McCoy's cells (obtained from E. Russell Alexander, University of Washington), were those of Smith et al.⁷ The Trichosel broth was incubated at 37° C and examined bi-weekly. The cultures were centrifuged lightly and passed once after a week if no *T. vaginalis* were observed.

Random serum specimens obtained from 97 patients attending the VD clinic and 100 sera from individuals of comparable age and sex, obtained from premarital serology, were examined for antibody to *Herpesvirus hominis*, cytomegalovirus, and chlamydia group antigens, using a

microtiter complement fixation technique.⁸ The antigen titers used were 1:64, 1:8 and 1:32 respectively; an antibody titer of 1:8 or greater in the test sera was considered positive. Antigens were supplied by the Center for Disease Control, Atlanta, Georgia.

EPIDEMIOLOGIC INFORMATION

Epidemiologic information was evaluated from VD clinic records on 107 patients with urethritis due to *N. gonorrhoeae* and 109 patients with non-gonococcal urethritis seen between January and March 1975. The diagnosis of gonococcal urethritis was established when culturing *N. gonorrhoeae* was cultured from the urethra. Men presenting with signs and symptoms of urethritis, in whom no gonococci could be demonstrated on a Gram stain and on culture of urethral scrapings, were considered NGU patients. The Chi-square test was employed to test the statistical validity of the observations.

Results

The various agents isolated from the study group of 26 patients are shown in Table 1.

TABLE 1.—Agents isolated from the urethra of a study group of 26 male patients with non-specific urethritis.

<i>Chlamydia trachomatis</i>	11/26	42%
<i>Trichomonas vaginalis</i>	1/26	4%
<i>Herpesvirus hominis</i>	1/26	4%
<i>Neisseria gonorrhoeae</i>	1/26	4%
<i>Corynebacterium vaginale</i>	0	0
Cytomegalovirus	0	0
Total	14/26	54%

Chlamydia trachomatis was recovered from eleven of the 26 patients (42%). *Trichomonas vaginalis*, *N. gonorrhoeae* and a probable *Herpesvirus hominis* were isolated in one instance each. The identification of the herpesvirus isolate was made on the basis of a typical cytopathogenic effect in W1-38 cells developing within a few days after inoculation. No cytomegalovirus or *Corynebacterium vaginale* were isolated. Thus, a possible etiologic agent was recovered in 54% of the 26 patients.

Physical findings in the study group of NGU patients were minimal, (Table 2). The description of discharge, whether absent, mucoid or

TABLE 2.—Pertinent physical findings in the non-gonococcal urethritis (NGU) study group.

Meatal inflammation	12%
Prostatic pain	8%
Inguinal adenopathy	8%
Conjunctivitis	8%
Oral-pharyngeal lesions	4%
Penile lesions	0
Anal lesions	0

purulent in these patients, did not provide a useful clue to the diagnosis of *C. trachomatis* urethritis. The presence of a heavy urethral dis-

charge, however, might be considered less suggestive of the NGU syndrome (Table 3). The one patient in whom *H. hominis* was isolated had no demonstrable urethral discharge.

TABLE 3.—Description of the urethral discharge in the non-gonococcal urethritis (NGU) study group.

AMOUNT	NUMBER OF PATIENTS	CHARACTER	NUMBER OF PATIENTS
Absent	7 (3)*	Purulent	9 (5)
Scant	16 (7)	Mucoid	10 (3)
Moderate	3 (1)	Absent	7 (3)
Heavy	0		

*Number of *C. trachomatis* isolations in parenthesis.

Urethral bacteriology results in the study group are recorded in Table 4. *Staphylococcus albus* and diptheroids were the most commonly isolated bacteria. No *C. vaginale* was isolated. One

TABLE 4.—Bacterial isolations in the study group of non-gonococcal urethritis (NGU) patients.

Diphtheroids	16/26
Staphylococci	15/26
Streptococci	3/26
Gram positive rods	1/26
Gram negative rods	1/26
<i>N. gonorrhoeae</i>	1/26
No growth	5/26

	CHLAMYDIA PATIENTS (TOTAL=11)	UNDIAGNOSED PATIENTS (TOTAL=12)
No growth	4	0
Diphtheroids only	2	3
Staphylococci only	0	2
Diphtheroids and staphylococci	5	5

patient was shown to have *N. gonorrhoeae*. When the bacteriology of the *C. trachomatis* isolation patients was compared with that of the undiagnosed urethritis patients, the only remarkable finding was that 4 out of 11 patients with *C. trachomatis* infection had no growth, while all of the undiagnosed patients had some recoverable bacteria in their urethra (Table 4).

Antibody prevalence to *Herpesvirus hominis*, cytomegalovirus and a chlamydia group antigen was determined in 97 random sera of patients seen at the VD clinic. Comparable sera matched for age and sex from general population were also screened (Table 5). Antibodies to *H. hominis* and the chlamydia group antigen were found to

TABLE 5.—Complement fixing antibody prevalence to various antigens in venereal disease clinic and general population sera.

ANTIGEN	GENERAL POPULATION
<i>Herpesvirus hominis</i>	50% (50/100)*
Chlamydia group	52% (52/100)
Cytomegalovirus	62% (62/100)

*Number of positive sera over the number tested in parenthesis.

be significantly higher in the VD clinic population group. There was no significant ($P>.05$) difference in the prevalence of antibody to cytomegalovirus between the two groups.

While the Venereal Disease clinic maintains records on the number of male patients evaluated for urethritis and on the number positive for gonorrhea, the diagnosis of NGU is not specifically recorded. However, the difference between the total number of symptomatic patients and those positive for gonorrhea represents a good estimate of the number of males entering this clinic with NGU. The monthly incidence of gonococcal and non-gonococcal urethritis seen at the VD clinic between June 1973 and September 1975 is illustrated in Figure 1. NGU patients accounted for 69-82% of all male patients being evaluated for genitourinary symptoms at the clinic during this period.

Epidemiologic information from 109 NGU patients and the 107 gonorrhea (GC) patients contained some significant differences. In general, the NGU patients tended to be older ($P<.0005$), Caucasian ($P<.01$), have a longer duration of symptoms before coming to the clinic (Table 6), and engage in sexual intercourse despite symptoms more frequently ($P<.0005$).

TABLE 6.—Duration of genitourinary symptoms prior to clinic visit in men with symptomatic urethritis.

	NON-GONOCOCCAL URETHRITIS	GONOCOCCAL URETHRITIS
Mean	9 days	3 days
Median	4 days	2 days
Range	1 - 90 days	1 - 21 days

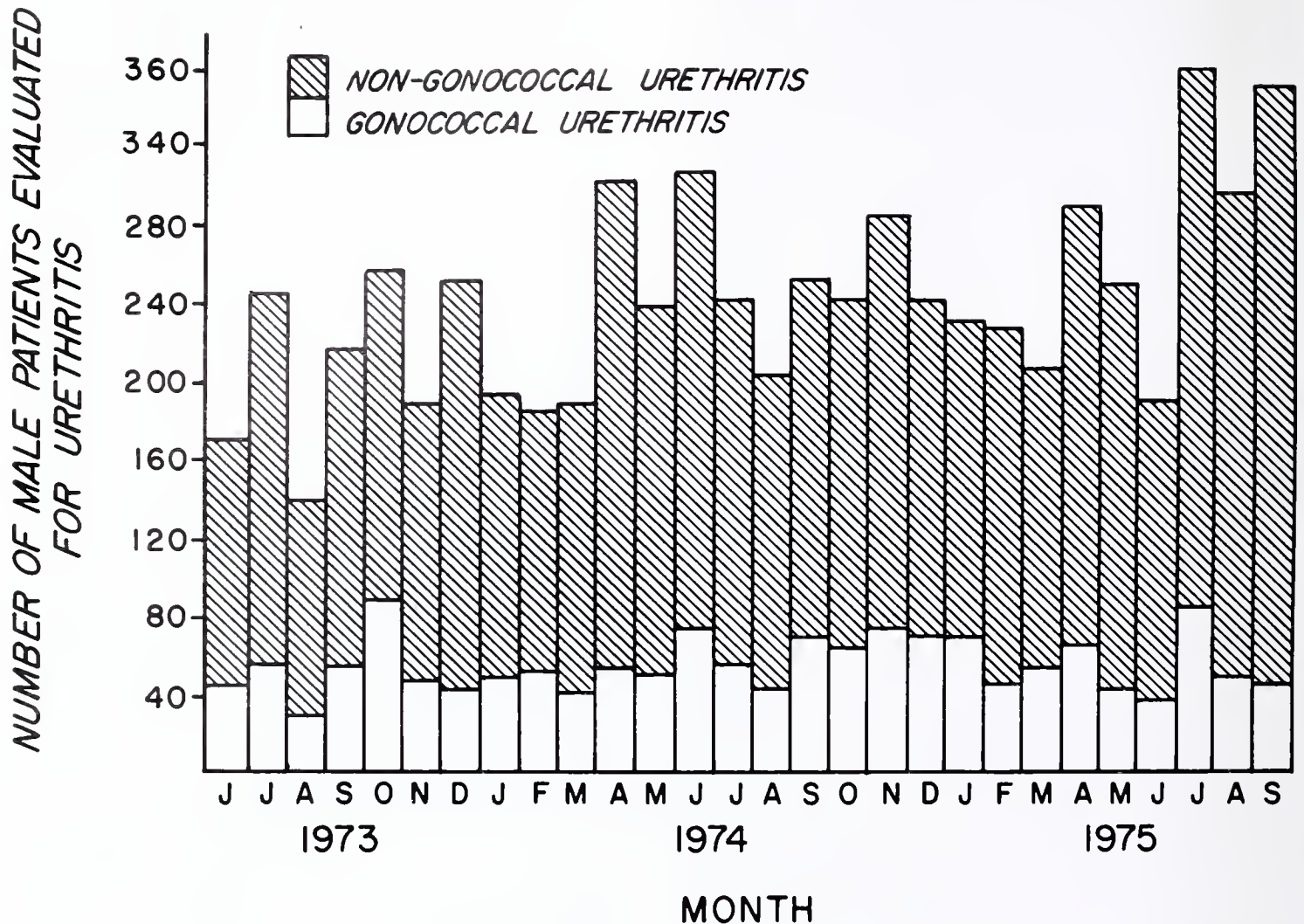
NGU patients (Table 7) had less acute symptoms of urethritis, as judged by the presence or absence of dysuria ($P<.0025$). NGU patients were

TABLE 7.—Presenting signs and symptoms in men with symptomatic urethritis.

	NON-GONOCOCCAL URETHRITIS	GONOCOCCAL URETHRITIS
Discharge and dysuria	50%	83%
Discharge alone	35%	15%
Dysuria alone	15%	2%

also more likely to have another episode of NGU ($P<.0025$), whereas GC patients were more likely to have a subsequent episode of GC ($P<.025$). Reactivation versus reinfection could not be distinguished. A history of having had prior venereal disease, undifferentiated as to type, was the same for both groups (43%).

FIG. 1.—Monthly incidence of male gonococcal and non-gonococcal urethritis evaluated at the Hawaii State Venereal Disease Clinic June, 1973 to September, 1975



Discussion

Evidence for a recently acquired *C. trachomatis* infection during episodes of NGU has been provided by a number of workers using isolation and serologic methods, providing accumulating evidence that *C. trachomatis* is a significant cause of NGU.^{4, 9-13} This study corroborates recent studies indicating *C. trachomatis* can be isolated from the urethras of a high percentage of men with NGU. In a controlled study by Holmes et al, *C. trachomatis* was isolated from 42% of NGU patients, and a 7% isolation rate being observed in a group of comparable controls.⁴ The isolation rate of *C. trachomatis* in our group of 26 patients was also 42%. Despite the lack of a control group and the relatively small number of patients, it is reasonable to assume that the incidence of *C. trachomatis*-associated NGU in Hawaii is similar to that elsewhere. The practical implication of knowing that these agents are responsible for a significant proportion of NGU is that males with a urethral discharge are frequently assumed to have gonorrhea and are treated as such with penicillin; however, penicillin is not an effective antimicrobial in chlamydial urethritis, tetracycline being generally the best form of therapy in such cases.¹⁴

Only one isolate each of *Trichomonas vaginalis* and *Herpesvirus hominis* was made from the studied patients. These agents are known causes of NGU, but apparently account for only a small percentage of the total number of cases.^{15, 16} The absence of culturable aerobic bacteria from the anterior urethra in *C. trachomatis*-positive NGU patients has been observed before,⁴ the significance of this finding is unexplained. One patient in the study group was found to have gonorrhea. This patient presented less than 24 hours after his presumed exposure and was included in the study group because gonococci could not be demonstrated on an initial Gram stain. He subsequently developed culture-proven gonococcal urethritis. This suggests that early gonorrhea may mimic NGU. Mildly symptomatic gonorrhea and L-form gonococci are known to exist but their role in the syndrome of non-specific urethritis is not known.¹⁷

Mycoplasma, particularly of the T-strain, have been implicated in the etiology of NGU, but their role is controversial. These organisms were not examined in this study because, in general, they have not been recovered from a significantly greater proportion of NGU patients when the isolation rates were compared to adequately matched controls.^{4, 18} There is recent evidence,

however, suggesting NGU patients may quantitatively have more urethral T-strain mycoplasmas than a matched control group.¹⁹

Previous investigators have observed that NGU seems to occur more frequently in Caucasians.^{2, 20} However, these studies contrasted populations which were comprised primarily of Caucasians and Blacks.^{2, 20} The findings in this VD clinic population corroborates a higher incidence of NGU in Caucasians, but in a multi-racial population. The reasons for this observation are not clear. Differences in susceptibility, exposure and attitudes toward having a urethral discharge are all potential influencing factors.

The genitourinary symptoms in NGU patients were noted to be less severe than those observed in gonorrhea patients. This may account for the tendency of NGU patients to disregard their urethritis and delay seeking treatment. That these patients engaged in sexual intercourse despite signs and symptoms of urethritis has important implications in the potential spread of NGU due to infectious agents. Other investigators have also recognized a milder and more indolent disease in NGU patients when compared to patients with gonorrhea.²¹ The minimal physical findings as observed in the study group are typical of patients with NGU.

The overall percentage of men with a past history of any venereal disease was the same for both the GC and NGU patients (43%). However, patients with NGU were noted to have an increased chance of having another episode of NGU. Likewise, patients with GC were noted to have a greater possibility of having a subsequent episode of GC. NGU patients however, were at a significantly greater risk of developing another episode of NGU. Whether this is due to reinfection or relapse could not be determined in this study; however, there is suggestive evidence NGU patients tend to have relapses.²²

Clinical disease due to genital herpes has recently been noted to have increased markedly in certain areas of the United States.²³ The high

prevalence of Herpesvirus antibody amongst this VD clinic population is suggestive that genital herpes is also an extremely common infection in this population. *Herpesvirus hominis* has been isolated from male patients with urethritis in whom there was no history or clinical evidence of a genital herpes infection, indicating this virus may account for some cases of NGU.¹⁶

Antibody prevalence to cytomegalovirus was not found to be significantly increased in the VD clinic sera. Sexual transmission of this virus has been suggested as a possible mode of spread.²⁴ However, there is no evidence cytomegalovirus plays a significant role in the etiology of NGU.⁴

The prevalence of antibody to a chlamydial group antigen, as measured by the complement fixation test, was found to be significantly higher in the VD clinic population. The complement fixation test is a relatively specific indicator for chlamydial infection; however, it is an insensitive measure of genital chlamydial infections.²⁵ The high prevalence of complement fixing antibodies suggests infection by agents belonging to the chlamydia group of organisms is common in Hawaii. The implications of this are not clear because clinical disease due to these organisms, aside from the described genital infections, is not generally apparent.

In the study group evaluated, a probable etiology was established for 54% of 26 patients. Considering that 69-82% of all male patients presenting to the VD clinic have NGU, and assuming in only about half of these cases can the etiology be ascertained by current methods, there is a sizable segment of the urethritis population for which we do not have an etiology, good recommendations for therapy nor established modalities for control.

Acknowledgement

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. . . on the agonies of surfing

Surfer's Elbow

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• *Talking to many surfers and physicians in Hawaii about medical problems relating to surfing, we have noted a condition that we have named "surfer's elbow," a painful elbow following a few days or a week of increased, intensive surfing. We report here this phenomenon, the factors influencing its occurrence, and its treatment.*

Report of a Case

A 30-year old physician had surfed 2 to 3 times a week for 4 years without any medical problems. During one summer, after surfing once a day for 5 consecutive days, he noticed a sharp ache in his right elbow, made worse by jerky, twisting movements. After resting and completely abstaining from surfing for a week, the pain went away. The following week he again surfed 5 of 7 days, and the pain returned, intensified this time. The pain gradually subsided during a month's abstinence from surfing. He then returned to his regular 2 to 3 times a week surfing schedule. On

followup one year later there was no further recurrence of elbow pain.

Comment

Surfer's elbow is probably a form of tennis elbow, an epicondylitis characterized by pain usually over the lateral aspect of the elbow, aggravated by wrist and finger extension and by tenderness over the lateral epicondyle and/or radiohumeral joint. The main accepted cause of tennis elbow is excessive demand or overload on the extensor muscles of the wrist and fingers. These muscles have their origin at the lateral humeral epicondyle.

In surfing many activities produce trauma and overload the elbow. They are swimming, paddling through calm water and crashing waves, holding on to loose boards as waves break, waxing, mounting and carrying the board. The type of surf, wave size, frequency and duration of surfing time directly affect the elbow.

The new smaller boards, less than 8 feet long, produce even more stress on the elbow than larger boards. They do not glide as well as the

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long boards, they limit paddling to a prone position, and are also harder to paddle.

We sent questionnaires to orthopedic and general practitioners in Honolulu, seeking the frequency of elbow problems. Three of 14 orthopedic surgeons and 2 of 15 general practitioners stated they occasionally see elbow problems related to surfing, while the others said they rarely see this problem. We also questioned 100 surfers who had surfed regularly for at least one year. Six had experienced elbow pain made worse by excessive surfing. Surfers may not report this to physicians as often as might be expected because surf conditions usually do not stay ideal for long. Therefore, many surfers are forced to rest until "surf's up" again.

Treatment of this condition should begin with preventive measures:

1. Limiting frequency and duration of surfing.

2. Using bigger, more buoyant boards so that one can sit, knee, as well as prone paddle. By varying the ways of paddling, the elbow is not overly stressed.

3. Mounting the board with attention on not putting weight and pressure on the elbows.

4. Controlling the board with one's legs while resting in the water rather than holding mainly with the hands and arms.

If a painful elbow occurs, we recommend rest and abstaining from surfing or any activity that stresses the elbow for at least 7 days. If symptoms persist, the following should be considered: application of ice immediately after surfing, anti-inflammatory agents, analgesics, steroid injections, or surgery.

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landmark estates



President's Newsletters to the HMA membership hopes to keep all of you up-to-date on the latest developments in the major areas. Your HMA President is very concerned that you understand what is occurring in our State that affects **you**. I hope you do take time out to peruse these newsletters. If you have any suggestions, please forward them, as well as any comments, to President Cal Sia.

HEW Released the names of 409 physicians who received \$100,000 or more through Medicare payments during 1975. AMA took strong issue with such release, stating: "There is something basically dishonest in the broadcast release of the names of physicians who receive Medicare payments. Much of the listing is based on payments made to patients, and there is no way to know whether the physicians were ever paid. HEW knowingly released an inaccurate list of names." One week after the release by DHEW, errors in the listings were piling up. Of the first 112 physicians checked by AMA, only 32 were correct as listed. Examples include one physician listed as practicing in Illinois and receiving \$233,871 from Medicare in 1975, has been retired in Arizona for 12 years. Besides, he is a pediatrician and did not practice at all in 1975. Another physician, listed as receiving \$258,139 in 1975, had died in 1974. I hope HEW learns.

AMA Says that the words "fraud" and "abuse" are often used interchangeably in reporting problems with persons and agencies providing service to Medicare and Medicaid patients. But there is a distinction. The term "fraud" is defined, for purposes of imposing penalties under the Social Security Act, as the making (or causing to be made) of "any false statement or representation" of a material fact "willfully, knowingly, and with intent to deceive." As such, it is

subject to conviction of a misdemeanor and fines. The term "abuse" may include fraud, but is not necessarily fraud. The term "abuse" is defined as "a corrupt practice or custom; improper use or treatment; or misuse." The term "abuse" is commonly used to refer to overutilization of medical and health services or the provision of services not considered medically necessary. The criminal intent of "fraud" may be absent in such cases. Less confusion in the public's mind might occur if the terms were not used interchangeably.

Approximately 6,000 medical students and physicians-in-training borrowed \$7.8 million in 1976 from the AMA-ERF student loan program to help meet medical education expenses. Loans to medical students (5,055) accounted for 91% of all loans through AMA-ERF last year. Since the program began in 1962, more than \$77 million in loans have been arranged and guaranteed by the AMA-ERF.

And Speaking Of AMA-ERF, the HCMS Auxiliary would like to remind all physicians that the national AMA-ERF closes its books on May 28, 1977, and there is still time for physicians to donate to the AMA-ERF. We all recognize that many physicians send donations directly to their medical schools; however, it would be fitting to support the AMA-ERF and the UH Medical School. We issue a plea for your support of AMA-ERF. Make checks to AMA-ERF and send to the HCMS Auxiliary at 320 Ward Ave., Suite 200, Honolulu 96814.

An Analysis Of Physicians' Fees for the years 1971-1975 show that, while physicians' fees have been rapidly rising, their *fees* have not been rising as rapidly as their business expenses, and physicians' *incomes* per patient visit have not risen as much as the cost of living. Data from the Consumer Price Index and DHEW data demonstrate this in the following:

INDICES OF PHYSICIANS' FEES AND COST OF LIVING
(1971=100)

	1974	1975
Physicians' Fees	116.3	130.5
Business Expenses Component	118.5	133.1
Physicians' Income Component	114.7	128.8
Cost of Living (CPI, all items)	121.8	132.9

An HMA Member sends in a news article which notes that the U. S. Dept. of Justice, which has been looking at the antitrust implications of doctor advertising, is beginning an investigation of medical malpractice insurance companies that earn large profits in states where they are the sole carriers or sell the only new policies. A Justice Dept. spokesman says the probe is likely to focus on companies whose rates appear excessive compared with those in states with similar malpractice experience or on those cases in which insur-

ance commissioners have approved high rates only after an insurer has threatened to pull out of a state altogether.

American College of Chest Physicians has three postgraduate courses to announce:

"Current Status and Controversies in Pace-making," Hilton Head, South Carolina, June 23-25, 1977. Twelve credit hours for Category 1. Tuition fees charged.

"Chronic Obstructive Pulmonary Disease," Seattle, Washington, June 16-18, 1977. Fifteen and one-half credit hours of Category 1. Tuition fees charged.

"Lung Cancer," Mayo Clinic, Rochester, Minnesota, June 2-3, 1977. Eleven credit hours of Category 1. Tuition fees charged.

For further information on above three courses, contact Mr. Dale E. Braddy, Director of Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois, 60068.

During 1977, The AMA Will Sponsor six regional workshops for hospital staff members, among which the numerous topics will include medical staff management problem solving and medical risk management. Seminars to be held Fairmont Hotel, San Francisco, April 22-23; Marriott Motor Inn, Atlanta, Georgia, June 10-11; Carrousel Inn, Columbus, Ohio, Sept. 16-17; Marriott Motor Inn, Philadelphia, Sept. 23-24; Marriott Motor Inn, Chicago, Oct. 7-8; Marriott Motor Inn, Dallas, Nov. 4-5. For more information, contact AMA, Dept. of Hospitals and Health Facilities, 535 No. Dearborn St., Chicago, Illinois 60610.

AMA Announces the 16th National Conference on Physicians & Schools, Regency Chicago, Chicago, Illinois, November 10-11, 1977. For more details, contact AMA, Division of Scientific Activities, Dept. of Health Education, 535 No. Dearborn St., Chicago, Illinois 60610.

University of Hawaii offers its second annual Summer Institute in Gerontology. First session -

May 31 to June 10; Second session - June 13 to June 24; Third session - June 27 to July 8. For information and applications, contact Dr. Jim Kelly, Summer Institute on Gerontology, Director, University of Hawaii, School of Social Work, 2500 Campus Road, Honolulu 96822.

Overseas Postgraduate Courses:

The First International Congress on Cardiac Rehabilitation will be held in Hambury, Germany, Sept. 12-14, 1977.

The First Mediterranean Conference on Medical and Biological Engineering will be held in Sorrento, Italy, Sept. 12-17, 1977.

For further information on either of above, contact Morton E. Berk, M.D., phone 537-2211.

Established General Practitioner plans to retire in near future. Would like to know of any physicians interested in taking over fully equipped medical office. Terms negotiable. Contact HMA office at 536-7702 for further information.

The **U.S. Food & Drug Administration**, San Francisco Office, invites all interested physicians to meet with the newly appointed Commissioner of FDA, Donald Kennedy, Ph.D., on Friday, June 10, 1977, 1-5 p.m. at the St. Francis Hotel, Geary & Powell Streets, San Francisco. Dr. Kennedy would like to hear the concerns of physicians. Topics include new drug approvals, laetrile, new medical device laws, and OTC drug changes. Please register by writing to the FDA, 50 U.N. Plaza, Rm. 524, San Francisco, CA 94102.

Happiness—this year's Kauaikeolani Children's Hospital benefit on Saturday, May 7, is headlined by Alan and Julie Grier. A show, produced and directed by Ed Kagihara, features happy and delightful songs sung by the Griers; the Happiness Singers (a chorale group composed of physicians' wives, residents, and nurses), and the Kauaikeolani Keiki Chorus, 18 talented children of the Hospital staff under the direction of Ms. Eunice DeMello, choir director at St. Clement's Episcopal Church.



THE KAAHUMANU BUILDING *"Ideal for Professionals"*

A NEW, QUALITY OFFICE BUILDING CONVENIENTLY
LOCATED BETWEEN PEARL CITY AND PEARL RIDGE

- * Under construction — opening in July
- * Design flexibility — suites from 400 sq. ft.
- * Cost savings now before completion
- * Free space planning

FOR LEASING INFORMATION CALL

HANSON REALTY CORPORATION

536-6288 or 537-5541

Also featured are the Floating Ribs, a quartet composed of Doctors Ed Kagihara, Al Dennis, Norm Kelley, and Phil McNamee. Dr. George Takushi will again provide the show music as well as the dance music with the big band sounds of yesterday and contemporary music of today.

No host cocktail hour will begin at 6:30. Dinner begins at 7:30 and the "HAPPINESS" show at 8:30. Following the show, there's dancing to Dr. George Takushi's "The Torchers" to round out the evening.

Ticket prices are \$25 for show, dinner, and dancing. Cabaret tickets (exclude dinner only) are only \$5. Dress will be casual; no coats or ties required.

For further information call Janice Gotz at 531-3511. Checks may be mailed to Kauikeolani Children's Hospital, 226 N. Kuakini St., Honolulu, Hawaii 96817. (All checks payable to Kauikeolani Children's Hospital Building Fund).

Established Clinic in Honolulu looking for internist or general practitioner. Interested physicians call HMA office at 536-7702.

Wanted: office x-ray, centrifuge, autoclave, EKG. If anyone has for sale, please call HMA office.



... the lifters and the leaners,
once more.

More than ten years ago, in fact it was in the Nov/Dec 1966 issue of this Journal, this editor wrote to exhort the "leaners" to join the "lifters" and work together for our profession. And again, in the July/Aug 1969 issue, there was more

of the same on these pages. Now it is time once more to review the record. The *causus belli* this time is the "Dang Plan."

First, let's take our good, dedicated, hard-working and selfless past-president Bill Dang (all our presidents have been selfless as president!) off the hook by calling what he dreamed up by its right name: HMA's Capital Fund.

The HMA has long been in need of capital. It had survived for nearly 120 years precariously, financially speaking, on the income from dues. A few years ago there was a great howl from the membership when a drastic increase in dues was made necessary because the HMA had been ignoring the portents for a major deficit for too many years before. There was even a greater howl once, when an attempt by the leadership to initiate a capital (building) fund by means of an assessment brought to a meeting the largest turn-out in the history of Hawaii's medical profession ever!

By expanding into the area of Federal grants such as EMCRO, EMS, PSRO, etc., HMA has more recently derived the benefits of indirect costs that are allowed institutions with a forward look, such that we are now a \$500,000 plus organization. Still, the dues have been going up steadily for the most part. We have also reached the 1000 member mark.

The work in which HMA is engaged has increased commensurately and many benefits have accrued to the membership therefrom. The old quarters on the second floor of Mabel Smyth were bursting with files and HMA's loyal personnel corps could hardly function efficiently for lack of elbow room. HMA has continued to be the body of the dog to the tune of 60% of income and expenditures. The dog did have a big tail, however, with HCMS sharing 40% of the load, but one must remember that HCMS encompasses most of the physicians in the State—87%. The tail may wag vigorously, but the body stands pretty firm!

The need for developing a capital fund was obviously there and at the annual meeting in 1975 the House of Delegates did approve the concept of funding through a program of long-term loans, non-interest-bearing, from the members to HMA.

An assessment of all members would have allowed for tax deductibility, yes, but it would have imposed a hardship on many. Previous attempts to go this route have still left some raw, open wounds and much ire.

Members should realize that the basis of the HMA Capital Fund Program is: Join Your Colleagues and Peers to **Help Your HMA**. The loan is purely for HMA's benefit, even though you will derive indirect benefits. It is not meant to benefit the member/contributor by tax breaks, high-interest investments, or the like. The loan is refundable, and it will be refunded, in time. The member who lends HMA the money is shoring up the edifice—a true "lifter." He is a "leaner" if

he is looking at the Plan in terms of self-aggrandizement or to derive pecuniary benefit therefrom.

Members can be assured that future benefits will become direct and personal once 320 Ward Avenue is paid for. The building generates an income of circa \$120,000/annum now, and this does not include HMA's paying some \$28,000 a year for its now adequate 2,611 square feet of space. HMA used to pay Mabel Smyth \$80,000/annum in rent; instead, it is now paying into its own equity. Once the building is paid for, the rent from the tenants could well support HMA as a dues-less organization! This would apply to *all* members—not just the ones on Oahu.

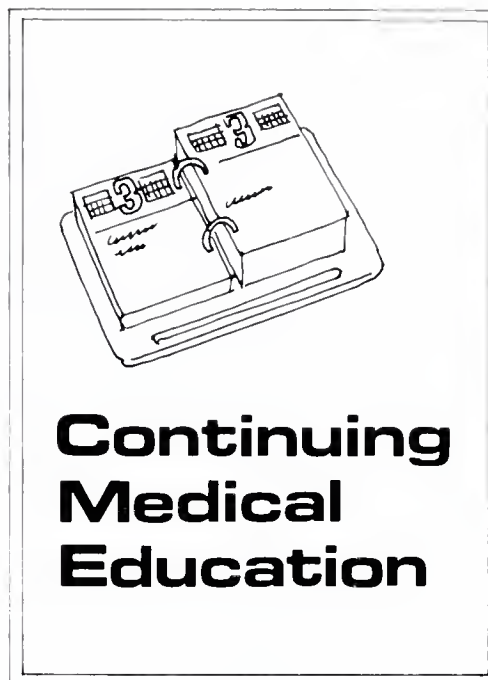
The development of the HMA Capital Fund and the acquisition of 320 Ward just happened to coincide. Both were approved by the same House of Delegates. Both had been thoroughly studied by experts and reviewed by HMA committees and its Council at meeting after meeting. Both projects look to be as good now as they did initially as mere concepts. Both have been thoroughly publicized to the membership directly and through the several County Societies, and if some members still don't understand what it is all about, then the fault lies in the eyes and ears and comprehension of the beholder. Certainly there has not been a dearth of disseminated information.

The three options have made it easy for members to contribute and participate. If all the members who are eligible (839 by latest count) had chosen Option #1 and had contributed \$900 in cash (10% discount) initially before 31 March 1976, with accrued interest, 320 Ward could have been bought nearly outright. The \$120,000/annum income from rents could be reducing our dues **now!** As it is, there are 84 members who have done just this in contributing; there are 385 who have promised to pay \$100/annum, and there are 140 members who are doing it by paying \$10 a month.

There are still 230 members of the 839, who have not committed themselves to support their HMA's Capital Fund; the grace period will expire on 30 April—a whole year beyond what it should rightfully have been. If these 230 do not commit themselves now, and thereby deprive themselves of membership in HMA, it will be a sad thing for HMA and for organized medicine. It will be even a sadder day for the drop-outs. May they not sleep well, knowing they have let down those "lifters" who have worked so hard for so long in order that so many of their colleagues will be benefited—the "leaners" as much as the "lifters."

One can give support to the organization of one's choice in only three ways: (a) By participating and working within it; (b) by contributing dollars that will work for the organization, or (c) by doing both.

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1½ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

(Contact CME Dept. for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium

Basic Science Lectures, Every Wednesday 7:15 a.m.,
Surgical Conference Room

3. Ob/Gyn Conferences, 2nd and 4th Mondays,
12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday,
7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays,
12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except
the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m.,
Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference,
as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday,
11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday,
11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m.
(Contact H.P. Stern, Capt, M.D., MC at 449-9742)

St. Francis Hospital

1. Medical Grand Rounds, Tuesday (4th & 5th)
12:30-1:30 p.m. Sull. IV Classroom
2. Surgical Grand Rounds, Fridays (except 4th)
7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Surgical Mortality & Morbidity Conference,
last Friday, 7:30-8:30 a.m.
7. Saturday Teaching Rounds, Saturdays (except
4th) 7:30-8:30 a.m.
8. Orthopedic Departmental Conf. 3rd Friday ea.
month. 7:30-8:30 a.m. Med. Staff Board Rm.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday,
7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr.,
Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—
last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at
noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each
month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael
McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee
meetings, 1st Monday, 7:30 p.m. & 3rd Wednesday, 12:30
p.m. of each month in the 320 Ward Ave. Building. Contact
HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii
Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Honolulu County Medical Society and Local Hospitals,
Honolulu

Type: 1, 1 hr/day, 1 day/mo from 12 mos

Fee: None Methods: AV, O, Pan

Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Soci-
ety, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu
96817

Type: I, 1 hr/day, 1 day/mo for 8 mos

Fee: None Methods: AV, Clin C, O, Pan, R

Dates: Arranged; 8 hrs instruction


SPECIAL EVENTS

- | | |
|-----------------------------|--|
| Apr. 30,
June 7,
1977 | Management of the Surgical Patient. Stan-
ford Univ. Schl. of Med. Stanford, CA 94305.
Held at Mauna Kea Beach Htl. Kamuela
96743. 7 days 27 hrs. Fee \$275. |
| May 1-7,
1977 | Radiology-Univ. of So. Cal. Schl. of Med.
2025 Zonal Ave. LA 90033. Held: Maui
Surf Htl. Maui. 5 days 30 hrs. |
| May 7-14,
1977 | Diagnostic & Therapeutic Skills-Univ. of So.
Cal. Schl. of Med. 2025 Zonal Ave. LA 90033.
Held: Mauna Kea Htl. Kamuela, HI. 5 days. |
| May 7,
1977 | "Multi-Disciplinary Team Approach to
Cancer Health Care"-Sat. 7:30 a.m. 1 hr. Cat.
I. Kaiser Pac. Aud.-Kaiser Hsp. Hospital
Cancer Team. Contact: CME Dept. Kaiser
for further info. |
| May 14,
1977 | "Thyroid Function"-Sat. 7:30 a.m. 1 hr. Cat. I,
Kaiser Pac. Aud. Kaiser Hsp. Univ. of HI John
A. Burns Schl. of Med. Contact: CME Dept.
Kaiser for further info. |
| May 14-21,
1977 | Orthopedic Review-Univ. So. Cal. Schl. of
Med. 2025 Zonal Ave. LA 90033. Held:
Royal Lahaina Htl., Maui. 25 hrs. Faculty:
J. Paul Harvey, Jr., M.D. Dept. of Ortho-
pedics-U of SC. |
| May 21,
1977 | "Newer Developments in the Treatment of
Peptic Ulcer Disease"-Sat. 7:30 a.m. Kaiser
Pac. Aud.-Kaiser Hsp. 1 hr. Cat. 1. Speaker:
Myron Lezak, M.D. Contact: CME Dept.
Kaiser for further info. |
| May 28,
1977 | "Toward More Complete and Effective Pre-
Operative Patient Education."-Sat. 7:30 a.m.
Kaiser Pac. Aud.-Kaiser Hsp. 1 hr. Cat. 1.
Speaker: Ronald Pion, M.D. Contact: CME
Dept. Kaiser for further info. |
| May 26-30,
1977 | Patient-Oriented Applied Med. Advances-
Univ. of So. Cal. Extended Programs in Med.
Educ. 3rd & Parnassus Aves. San Fran. 94143.
Held: Mauna Kea Htl. Kamuela, HI. 5 days-
30 hrs. |
| May 31,
July 8,
1977 | Summer Institute in Gerontology-Univ. of HI
-Schl. of Social Work; HI Hall. Cat. 1 CME.
Contact: Jim Kelly, M.D., Dir. (808) 948-6623. |
| June 4,
1977 | Asthma-Planning For Diagnosis, Treat-
ment and Patient Education-Sat. 7:30 a.m.
Kaiser Pac. Aud.-Kaiser Hsp. 1 hr. Cat. 1.
Speaker: Alexander Roth, M.D. Contact:
CME Dept. Kaiser for further info. |
| June 11,
1977 | Ultra Sound-Sat. 7:30 a.m. Kaiser Pac. Aud.-
Kaiser Hsp. Speakers: Drs. Peter Clapp &
Gordon Ing. 1 hr. Cat. 1. Contact: Kaiser
CME Dept. for further info. |
| June 11-18,
1977 | Orthopedic Review-Univ. of So. Cal. Schl. of
Med. 2025 Zonal Ave., LA 90033. Held:
Mauna Kea Beach Htl. Kamuela, HI. 5 days-
30 hrs. |
| June 18,
1977 | Venereal Disease Part I-Venereal Infections
Exclusive of Gonorrhea-Sat. 7:30 a.m. Kaiser
Pac. Aud.-Kaiser Hsp. Speaker: Richard Far-
dal, M.D. 1 hr. Cat. 1. Contact: Kaiser CME
Dept. for further info. |
| June 18-25,
1977 | Lab Management for Pathologists-Univ. of So.
Cal. Schl. of Med. 2025 Zonal Ave., LA 90033.
Held: Mauna Kea Beach Htl. Kamuela, HI.
5 days-30 hrs. |
| June 25,
1977 | Amyloidosis-Sat. 7:30 a.m. Kaiser Pac. Aud.-
Kaiser Hsp. Speaker: Vera Hlaing, M.D. 1 hr.
Cat. 1. Contact: Kaiser CME Dept. for fur-
ther info. |
| June 25-26,
1977 | Geriatric Workshop-Univ. of HI & Schl. of
Med. Cat. 1-CME. Cost: \$100-practicing phys.,
\$50-retired phys. & no cost-students & resi-
dents. Contact: Jim Kelly, M.D., U of H |

- (808) 948-6623.
- Aug. 8-21, 1977 Visiting Prof. of Oncology, Am. Cancer Soc. HI Div. 200 N. Vineyard Blvd. Honolulu 96817. 10 days, 40 hrs. no fee. Ph. (808) 531-1662 for further info.
- Aug. 1977 20th Annual Postgraduate Refresher Course. Univ. of So. Calif., Schl. of Med. 2025 Zonal Ave., LA 90033. Held at Honolulu, Mani, Kauai, Kona. 37 hrs. Phil R. Manning, M.D. Assoc. Dean.
- Oct. 31, Nov. 4, 1977 HMA Annual Mtg.-AMA Regional. Sheraton-Waikiki, Honolulu. Contact: Mrs. Bess Chang -HMA 320 Ward Ave. S 200, Honolulu 96814 or (808) 536-7702.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1976 Supplement to JAMA or call the HMA Office.



**Hawaii
Academy of
Family
Physicians'
Newsletter**

J. J. FREDERICK REPPUN, M.D.

New Members—Jerry C. Calvanese, Capt. MC, USA, is a new Active member and at Schofield Barracks. He and his wife came to the 26 March dinner meeting and met a few people. Lloyd T. Kobayashi, UHSM'78 is a new Student member. Welcome!!

News of Members—We hear Verne Adams of Pahala on the Big Island plans to retire in September and move back to the Mainland. He is a charter

member of AAFP and has been active as a Councillor with HMA. **Kevin Kunz**, UHSM'78 is an officer of AMSA and currently in Washington, D.C. **Dale C. Wicklund**, MD'76 UHSM, is now a Resident Affiliate member at Tripler Army Medical Center. **Patrick Lowry** MD is on campus and enrolled at the UHSchPH. Back in the fold is **Vit Universal Patel** MD, a psychiatrist but interested enough in Family Practice to remain with us as a Sustaining Member. **Timothy David Woo** MD of Hilo has resigned his membership, much to our regret; he joined the Academy 24 years ago. **Guy Heder** MD of Kahuku is looking for a *locum tenens* 1 July to 15 Aug 77. The **Marc Shlachters** welcomed Kori on 20 Feb; Marc has his office in Hauula.

Photogenicity—big as life is **David Livingston's** picture in the newspaper ads for Honolulu Federal S&L. Prominently displayed in the AAFP REPORTER of April/1977 were our new officers **Lincoln Luke**, **Pat Dietrich** and **Tom Cahill**, together with a brief description of our annual meeting in January. Also photographed by **Felix Lafferty** and included in the REPORTER were "Dean" **Varian Sloan** and past-pres. **Don Farrell**. In the UH publication "Malamalama."

ABFP—Added to the roster of HAFP members who are certified ABFP, as of 1976, are **Ben K. Azman** MD and **Harold Machigashira** MD. Recertified in 1976 were members **Robert J. Harrison** MD and **Patrick J. Walsh** MD. Congratulations! This makes 24 of our members Board Certified in Family Practice. The upcoming dates for certification and recertification in 1977 are 28, 29, 30 October (but not in Hawaii). This will be the last opportunity for certification based on qualifying by any route other than Plan I (Family Practice Residency).

CME—Important for Academy members to note: The Big One—USC-UH 13-24 Aug 77 usually good for around 35 P. Stanford USM has one at Mauna Kea Beach Hotel 30 Apr to 7 May on Surgery but the credit hours are 22 E. New Mexico has a Family Practice Seminar at Mescalero 18-21 July for 17 hours of P credit.

Members are reminded that what the AMA approves as Category I is not necessarily AAFP Category P. Several have turned in Nadine Bruce's listing of CME courses at St. Francis Hospital. These may be Cat 1 for AMA-PRA, but only some are for P for AAFP members. It is the member's responsibility to list his credit hours appropriately. As of this date, 4 members have not been cleared for recertification as of 31 Dec 76. They are **Cachero**, **Freeman**, **Hayes** and **Lawson**. The deadline **WAS** 31 Mar 77!



BLEMISHES?

COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

Lydia O'Leary
OF HAWAII

ALA MOANA CENTER—STREET LEVEL

PHONE 949-3288



**Friday, January 14, 1977, 4:30 p.m.
320 Ward Avenue, Suite 200**

CALL TO ORDER

The meeting was called to order by Dr. Calvin C.J. Sia. Also present were Drs. William W.L. Dang, Douglas Bell II, Grover H. Batten, Marion Hanlon, George H. Mills, Herbert Y.H. Chinn, Ann B. Catts, William Kepler, Richard Lundborg, Thatcher Magoun, Albert Chun-Hoon, George Goto, J.I.F. Reppun, John W. Edwards, Jr., Calvin Kam, Rowlin Lichter, Peter Kim, and Dr. Clifford Moran who was seated for Dr. Sakae Uehara. Dr. Leonard Howard was appointed to serve on the Council to fill the one-year unexpired term of Dr. Ann Catts. Also present were Drs. Roy Kuboyama, Paul Condit and Terry Wong. Mr. V. Thomas Rice, attorney, was also present.

MINUTES

The minutes of the October 1, 1976 meeting were approved as circulated.

REPORT OF THE SECRETARY

The secretary's report, as of December 31, 1976, indicated that there were 961 active members of the HMA. There were also 41 special members for a membership total of 1007. The number of delegates to the AMA is predicated on the Active membership and thus it appears that HMA will have only one delegate to the AMA in 1977.

REPORT OF THE TREASURER

November 1976 Financial Statement: The November 1976 financial statement was reviewed in detail.

ACTION:

It was voted to accept the November 1976 financial statement subject to audit.

The Dang Plan: Dr. Batten reported that contributions to the Dang Plan have increased considerably since the last mailing. The Capital fund balance sheet was reviewed in detail and accepted subject to audit.

Assistant to the President: Dr. William Dang was appointed to serve as Assistant to the President effective November 1, 1976. There were no objections to the appointment.

REPORT OF AMA MEETING

Dr. George Mills reported on the AMA meeting held in Philadelphia in December. Summaries of the AMA House of Delegates meeting are on file in the HMA office. It was noted

that the Delegates did support the submission of a comprehensive national health insurance program to Congress. It was also noted that due process is an issue that is of great importance nationally and it was also announced that Mr. Dick Layton, former AMA field rep to Hawaii, is now serving as the Director of the AMA's Medical Assurance Company.

REPORTS OF COMMITTEES AND COMMISSIONS

The Committee structure for 1977 was circulated. The election results for various commissions and committees was as follows:

Cancer Commission: Chairman, Grover H. Batten; members appointed for three-year terms were Drake Will—Hawaii Medical Association; Kirsten Vennesland, DOH; and Carl Boyer, Jr.—American Cancer Society, Hawaii Division.

HMA Finance Committee: Chairman, Grover H. Batten, Vice Chairman, John Edwards, Honolulu County Treasurer; members—M. AVECILLA, Albert Chun-Hoon, William Dang, Elmer Johnson, Richard Omura, and the Treasurers from Kauai, Maui and Hawaii counties.

Building Committee: Chairman, Calvin Sia; members—William Dang, Ann Catts, Douglas B. Bell II, William Kepler, Richard Lundborg, Thatcher Magoun and Grover Batten, ex-officio.

Bureau of Research and Planning: Chairman Herbert Y.H. Chinn; members (four to be elected). Fred Gilbert, George Mills, Henry Oyama and Livingston Wong.

HAMPAC Board: Five members from Honolulu; Richard Ando, Albert Chun-Hoon, Bernard Fong, Leonard Howard, Roy Kuboyama, Raymond DeHay, William Moore, Jr.; A.L. Vasconcellos, Calvin C.J. Sia, Timothy Wee, Thomas Whelan, Jr.; Mrs. Douglas Bell II, Mrs. George Mills, Mrs. Jerome Tucker and Mrs. Charles Yamashiro. Hawaii County—James Matayoshi and Pete Okumoto. Maui—Mark Sowers and Sakae Uehara. Kauai—Patrick Aiu, Katok Chuang, Peter Kim and Yonemichi Miyashiro. It was also announced that the following will serve as ex-officio consultants: George Goto, P.H. Liljestrand, L.Q. Pang and B. Allen Richardson.

REPORTS OF COMMITTEES RESPONSIBLE TO THE COUNCIL

EMS: Dr. Dang reported that the staff is presently considering sending in another grant for training of EMS personnel which would be good up to 1980.

ACT 219: Dr. Howard reported that the Ad Hoc Committee to amend Act 219 has been meeting weekly since mid-November. He noted that the total committee met with various members of the legislature and presented the HMA position. Meetings have also been held with various medical staff and with specialty societies. The committee is currently in the process of writing testimony to support HMA's position. A meeting is also scheduled with the representatives of the Board of Medical Examiners to discuss and review our proposal.

Diabetes: Dr. Terry Wong reported that in November 1975 Congress passed a National Diabetes Act which calls for the development of diabetes research and training centers throughout the United States. HMA has been interested in learning whether or not such a center might be based on Oahu. There were a number of meetings on this as well as a number of attempts to coordinate the interests of the clinicians in the community as well as research activities. At the present time there has not been any consensus of opinion regarding the formation of a diabetes center. January 15 was the first deadline for submission of grants for a diabetes center. It was felt that the committee did not have enough information or manpower or recognized people in the field of diabetes to pursue the research aspects. There was also the matter of a commitment of a person who might serve as Project Director or even part-time Director for such a project. It was noted that the House of Delegates had discussed this at

their October meeting and had agreed that it would be well for the HMA to pursue such a proposal.

ACTION:

It was moved, seconded and passed that the Diabetes Committee strongly pursue this proposal.

Self-Insurance: Dr. John Edwards presented a report of the AMA's Ad Hoc Committee on Self Insurance to the Council. The report outlined the various meetings and discussions that had been held over the past two months. The committee recommended that the HMA proceed, together with the Hospital Association of Hawaii in the development of a mutual non-assessable insurance company for purposes of providing professional liability insurance to the physicians of the State of Hawaii as well as general liability insurance to those hospitals that would participate in such a program. Prior to the actual formation of such a company, it was recommended that a consulting actuary be contacted and asked to develop and elaborate on the credibility criteria for such an insurance venture within the State of Hawaii. The committee is especially interested in knowing the number of doctors and the number of hospital beds that would be required to establish a credible company.

ACTION:

It was moved, passed and seconded to approve the recommendation of the committee.

The committee also felt that the management of the company should be of top notch insurance people and professional claims adjusters in the casualty line hired by the company and responsible to the company itself. The committee recommended that such responsibilities not be subcontracted to another organization if possible.

ACTION:

It was moved, seconded and passed to accept the recommendation of the committee.

Action was deferred on a recommendation of the committee to modify the limits of the patient's compensation fund. This will be explored in further detail.

The idea of a physician's cooperative plan was discussed at length. A cooperative, such as proposed, would require enabling legislation and it was, therefore, voted to refer action on the cooperative plan back to the committee. The committee also recommended that Mr. Larry Baker of the Argonaut Insurance Company be contacted and asked to clarify the intentions of Argonaut to the physicians of the State of Hawaii as to whether or not Argonaut intends to remain in the State and provide professional liability insurance on a long term basis. It was also recommended that Argonaut be asked what rate increase can be anticipated in the coming year.

ACTION:

It was moved, seconded and passed to approve the committee's recommendation.

Cancer Center Liaison: Dr. Paul Condit had been asked to chair an Ad Hoc Committee on the Cancer Center Liaison which is composed of HMA's representatives to the Executive Committee of the Cancer Center, representative of the Cancer Commission and Dr. Condit who is chairman of HMA's Cancer Committee. This committee will look into the activities presently underway at the Cancer Center of Hawaii and attempt to keep the community informed.

Building Committee: Dr. Sia reported that the Nurses and Physician's Exchange and the Hospital Association of Hawaii have now moved into the 320 Ward Building. Ninety-three percent of office space is now occupied.

REPORTS OF THE COMMISSIONS

A. Internal Affairs: The Publications Committee has reviewed the proposal of Elson Alexandre to publish an annual directory for the HMA. The terms of the contract were reviewed. The committee recommends that the Council approve the terms of the contract.

ACTION:

It was voted to approve the signing of the contract for

the publication of the annual roster. It was further suggested that the publishing company be asked to furnish a print of each member's picture so that it may be kept on file in the HMA office and to specify the number of directories that would be ordered each year.

Dr. Bell reported that the 1977 HMA Annual Meeting will be held in conjunction with the AMA's Regional Meeting from October 30-November 4 at the Sheraton Waikiki Hotel. The Scientific Program Committee recommends that the Council reconsider its decision to raise the registration fee for non-HMA members to \$50. The original request of the Scientific Program Committee was for a registration fee of \$25.

ACTION:

It was voted to refer this matter to the HMA Finance Committee.

Public Health: The Communicable Disease Committee had been requested to review the state requirement for a serological test prior to marriage. A report from the DOH was circulated to the committee. The committee recommends that the serological test be retained at the present time.

ACTION:

It was moved, seconded and passed to accept the committee's recommendation.

Cancer Commission: Dr. Sia reported that as of October 31, 1976 HMA's contract with the Research Corporation of Hawaii for the operation of the Hawaii Tumor Registry had expired. Since that time, Dr. Sia has queried both the Research Corp. and the U of H regarding the operation of the Cancer Center and the determination of policies and program direction. The Cancer Commission has been asked to analyze the purpose and value of the Hawaii Tumor Registry, the operation of the Registry and the Registry finances. Dr. Batten presented a preliminary report and noted the Cancer


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Commission would be reviewing this in greater detail. He also reported that the Commission had reviewed proposed Department of Health legislation relating to cancer studies which would enable the Hawaii Tumor Registry to provide information to the patient's hospital as well as update the names of the organizations with whom the Department of Health cooperates on cancer programs. The Commission believes the bill is not necessary at this time as the present system is working efficiently, the bill enables data from the registry to be circulated to the extent it becomes difficult to control, and the bill implies that the measure is necessary to conform to American College of Surgeons accreditation standards which is incorrect.

ACTION:

It was voted not to support this legislation if it is introduced.

Report on Other Committees: Dr. Sia reported that he and members of the HMA Executive Committee had met with various community leaders and representatives of government as well as the Dean of the School of Medicine and Dean of the School of Public Health to discuss various problems facing organized medicine. He also noted that representatives from the Hiroshima Medical Association visited with the executive committee.

UNFINISHED BUSINESS

HMA Suit: In late October, 1976, the HMA filed an injunction to oppose the mandatory insurance-for-licensure provisions of Act 219 (1976 Hawaii State Legislature). It is expected that the case will be heard in the courts in late January and a decision reached by early February. Mr. Rice's bill for services was reviewed and forwarded to the Finance Committee.

NEW BUSINESS

HAMPAC: Dr. Howard noted that AMPAC was invited by the HMA to present a political action seminar in Honolulu. The seminar will be held on Saturday, February 5 at the Sheraton-Waikiki. Several mainland speakers have been invited and Senator Daniel Inouye has been asked to present the keynote address.

Staff Reorganization: Mr. Won announced that the staff is being reorganized and introduced the executive staff as follows:

Andrew Saranchock, Assistant Executive Director; Thomas Leineweber, Executive Assistant-Personnel; Leslie Ajifu, Executive Assistant-Financial Management; Paul Steward, Administrative Assistant, Publications; Becky Kendro, Administrative Assistant-Community Affairs; Bess Chang, Administrative Assistant Internal Affairs; and Irene Wong, Administrative Assistant, Special Affairs.

AMA Board of Trustees: Dr. Mills announced that he is running for the AMA Board of Trustees in 1977. He noted that he will have two opponents.

ACTION:

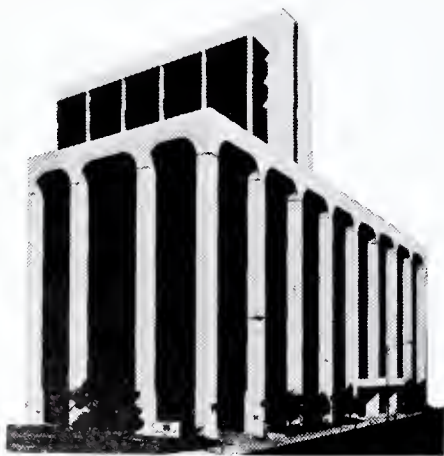
It was moved, seconded and passed that the Council support the candidacy of Dr. Mills for AMA Trustee and a budget of \$1,000 be set aside for this purpose.

ADJOURNMENT

The meeting adjourned at 10:25 p.m.

DOUGLAS B. BELL II, M.D.
Secretary

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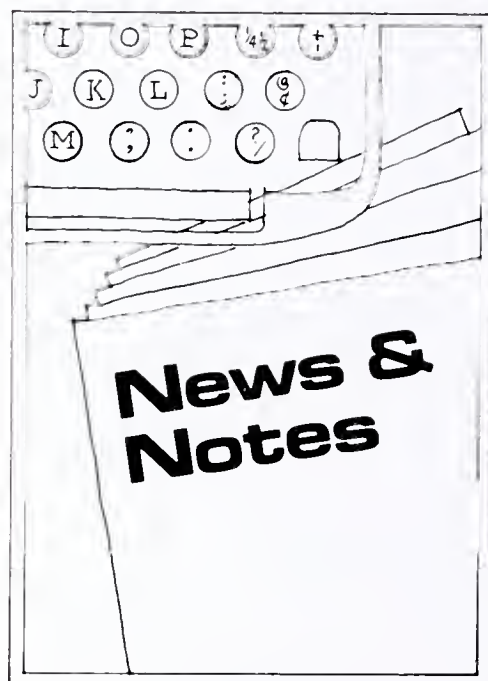
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Life In These Parts

Bulletin board, Kuakini 5th floor: "CAUTION—Be Sure Brain Is Engaged Before Putting Mouth In Gear."

Francis Oda was mystified by the following conversation between his 6 and 9 year old sons . . . Jeff the younger: "I've got a boner." Jonathan: "How come?" Jeff: "From watching the TV show." The venerable father learned that "boner" was the now generation term for erection . . . (This prompts us to relate the story of the OB Gyn man who was showing an unusually large expectant mother an X-ray of her unborn baby . . . She asked for the baby's sex. He explained that it was impossible to tell sex from an X-ray . . . She felt that it should be a simple matter of looking for the bony penis.)

Endocrine man **Werner Schroffner** reported at the American College of Physicians Hawaii regional meeting of a 25 year old man who had his pituitary removed 5 years ago for tumor. The man was first given chorionic gonadotropin in-

jections which made him sexually potent, but still infertile. Then a 32 week course of menopausal gonadotropin (sic) was initiated to increase the sperm count and Eureka! he became the father of his first child . . .

Lindy Chun reports that from a volunteer screening program in 29 Oahu schools where there is a high Hawaiian and part-Hawaiian population, instead of the expected 8.5% incidence of strep, there has been a 20% incidence in the 1500 youngsters already screened . . . **Danelo Canete**, president of the Hawaii Heart Association, states that the young part-Hawaiian population of the State are statistically more prone to rheumatic fever . . .

Item from Dave Donnelly's column: "Kailua physician **Dr. Dale Adams**, who once paddled his one-man kayak from Molokai to Hawaii Kai, has another feather for his cap. He single handedly rescued a 16-foot fishing boat with two fishermen the other evening—in his kayak. He came across the boat near dusk and there was no time to alert the Coast Guard so he attached a line around his waist and paddling his kayak, towed the boat to safety . . ."

The newly established Sex Abuse Treatment Center at Kapiolani Hospital treated 81 rape victims during a recent 4 month period. Deputy state health director **Audrey Mertz** is asking that the Center, originally funded for \$200,000, continue to be funded after the present fiscal year ending July 3rd . . .

QMC radiotherapist **Carl Boyer, Jr.**, Pacific Health Research Institute director **Fred Gilbert**, and Cancer Center of Hawaii Director **Kevin Loh** spoke at the 5th Annual Oncology Nursing Conference held Mar. 25 at the Pagoda Hotel . . .

The Moksha, one of the largest ferro-cement sailing vessels in the world (90 feet long and weighing close to 100 tons and completed in 1972) developed a leak and went down in the predawn hours off Niihau. **William Montague Downs**, physician and captain and 7 other Kauai residents were rescued by a Navy ship . . .

Two of the 12 Kona physicians who lost their voting privileges at Kona Hospital in a January reshuffle by state health director **George Yuen** have regained their voting rights. They are **Edwin Willet** and **James Mayer** . . .

Eyeman **Thomas Maeda, Jr.** was called to treat Elvis Presley for a common eye infection recently, but because the infection requires followup treatment, "Elvis left town in a scurry, pulled up stakes and flew to Memphis" (Daacon—Advertiser columnist)

In 1976, HMSA with 484,000 members (55% of the state population) processed 4.3 million claims or one claim every 2 seconds . . . HMSA reported that in 1970, the average cost per hospital day was \$79 and in 1976, \$181. HMSA also reported that during the same period the average physician visit cost went from \$8 to \$13 . . .

Miscellany

The farmer and his wife had struggled all these years to send their 3 sons through college. One was a doctor, another an engineer and the third a lawyer. At a rare family reunion of the 3 sons, the father asked if the sons could throw a golden anniversary party for them. The doctor son explained that with the rising malpractice insurance premiums, he just couldn't do it . . . The engineer son had just returned from a European trip with a spendthrift wife and the lawyer son had just finished remodeling his home and adding a swimming pool. The disappointed farmer said reflectively: "You know, your mother and I were so busy sending you kids through school that we just never got a chance to get married . . ." The sons were dumb struck and chorused, "You mean we're bastards?" "Yep, cheap bastards," came the laconic reply . . . (Heard by **Bill Dang** at the Hiram Fong testimonial)

Did you hear about the teenage girl who came home from her first day in sex education and asked her mother if she could trade in her menstrual cycle for a Honda? (As told by **Sharon Bintliff**)

Sign posted in a pediatrician's office: "God Heals—The Physician Just Collects The Fees!"

Physicians Speak Up . . .

Rodney West officially retired from Straub after 42 years and says:

"Medicine is just like any other area of life . . . It's human nature to improve through competition." (re interhospital competition)

"Doctors like to take care of sick people and they wish all this other stuff would blow away . . . Today the physician is forced to second-guess himself and it costs the patient more—a lot more" (re the changing social climate which made the physician's role controversial)

"We can do a lot of tests today, and we know a lot more about our patients' conditions, but tests don't take care of people; doctors do . . . The most important medicine a doctor can give his patient is himself. If the young doctor could remember that, he will improve immeasurably his patients' care" (advice for young physicians)

From Daacon's Column, we gleaned the following item: "Honolulu dermatologist **Dr. Cyrus Loo** is quoted in National Enquirer on how handwriting analysis reveals hidden illnesses . . . 'I am a pioneer in using graphology to treat emotionally caused skin eruptions.'"

Professional Moves

We can smugly predict that this Year of the Snake will have the medical community squirming and turning in every direction . . . esp. with Queen's and Kapiolani hospitals vying to occupy their physician office spaces . . . There should be great turmoil . . .

It seems that we still have a few more turnovers left from February . . . In Honolulu, internist **Mark Toyokazu Kuge** associated with **Masato Ohtani** in Suite 309-310 Professional Center, Bldg. On the Big Island, internist **Frank D. Irwin** associated with the Hilo Medical Group and allergist **W.A. Shrader** opened his clinic at the Hamakua Infirmary, Honokaa. On Maui, psychiatrist **Jon Betwee** left the Maui Mental Health Center and opened his private office at 70 Central Avenue, Wailuku.

Well, on to March. Urologist **E. Lee Simmons** relocated to Room 200, Harkness Pavilion, QMC and OB man **Richard T. Arnest, Jr.** joined the Kaiser-Permanente Medical Care Program at 1697 Ala Moana Boulevard. More physicians relocated to the Kapiolani Children's Medical Center—viz surgeon **Walton K.T. Shim** and OB men **Murray S. Berger**, **Neal E. Winn** and **Roland Berman**. Pediatrician **Jeanette Chang** relocated to the American Security Bank Bldg. and internist **Alfonso Faustino** moved into Room 303, Professional Center Bldg. In Waianae, GP's **Robin Garvin** and **Joseph Mergens** joined the Waianae Coast Comprehensive Health Center. On the Big Island, GP **Carlo Brizzolara** joined the Kona Coast Medical Group, Inc.

We read with interest how pediatrician **Arnold Nurock** moved to Kauai in 1973 from Oakland, California where he was chief of the Birth Defect Center at Children's Hosp. Last November, after 20 years of pediatrics, he turned to hyperbaric medicine and now serves as the Kauai marine advisory agent for the Sea Grant program . . .

Sportsmen . . .

"**Dr. Leabert Fernandez** has signed up to go on **Jeanne Lum's** tennis tour to Spain in May—which is great because the cosmetic surgeon is also a whizz at treating tennis elbows. He learned how when he was a plantation doctor treating workers with elbows that got sore from chopping cane." (From George Daacon's column)

At the recent State Master's Short Course Meet at the U of H pool, Hilo physician **Pete Okumoto**, 60, turned in a record breaking 28.5 second time in the 50 yard freestyle, thus breaking the 60-64 age group record of 29.1 held by Honolulu physician **Harold Sexton** . . .

HEPA physician and "The Soccer Doctor" **Leo Crowley** has been a player, organizer, coach and referee of soccer since coming to Hawaii 8 years ago. Leo is the new commissioner of the local American Youth Soccer Association which has had

an enthusiastic support here since its introduction 3 years ago with 15 teams. It now comprises 140 teams with over 2000 competitors. "Some people have said that I was either dedicated or crazy. Others not so kind say I am both . . ." In keeping with his HEPA duties and the sport he loves, Leo sometimes skips going to bed for a night or two . . . "The secret is getting 10 hours of sleep at one crack whenever I have the chance . . ." (Sports columnist Dan McGuire)

The eight member family of **Dr. and Mrs. Hing Hau Chun**, the "Hunky Bunch," recently featured in "Runners World" magazine, jogged more than 25,000 miles in one year and wore out 24 pairs of running shoes. (Daacon)

Elected, Appointed, & Honored

The Transcendental Meditation program honored ten people from various fields for contributing to the progress and happiness of the community and included were **Jack Scaff** and **John Wagner** of the Marathon Clinic . . .

In Feb., the Hawaii Epilepsy Society elected **Ronald Yamaoka** vice president and for directors, **Harold Nekonishi** and **Jordan Popper** . . .

John McDermott, Jr., chairman of the U of H Med. School Psychiatry Dept., was named to a record 4th consecutive term as chairman of the committee on certification in child psychiatry of the American Board of Psychiatry and Neurology, Inc. . . .

The Board of Trustees, G.N. Wilcox Memorial Hospital, presented **Clyde Ishii** with a resolution expressing appreciation for his services to the people of Kauai and contributing to the medical community. Clyde was president of the medical staff in 1950, 1968 and 1969 . . .

Alice Broadhurst, a member of the Hawaii Division professional delegate for the American Cancer Society of Maui, is the Uterine Task Force Chairman. She will be on board the Butterfly Bus, a mobile clinic which offers pap screening throughout the island . . . **Russell Stodd** is the new Maui Unit president and **Robert Bird** a board member . . . **J. Mark Sowers**, president of the Maui Mental Health Association, announced the appointment of ex-brigadier general Albert Lemen (Ph.D. in Education) as the executive director of the Association.

In Hilo, the Chinese Civic Association paid tribute at a Diamond Restaurant banquet to **David Woo**, long time Hilo physician who has retired and is moving to Honolulu . . .

QMC chief pathologist **Drake Will** will testify before the National Commission on Smoking and Public Policy at its first of eight regional forums in LA . . .

Miscellany (From Paul Condit's Repertoire)

The Phoenician and Syrian armies faced each other on the battle field with their respective generals about to lead them into the fray . . . The brave Phoenician general on his black stallion summoned his aide who draped the general's body with a flowing scarlet cloak . . . The brave Syrian general on his white stallion turned to his own aide and asked why the scarlet cloak . . . "To hide any blood from wounds he receives, Sire . . ." the aide wisely surmised . . . The Syrian General trembled a little and with quavering voice ordered, "Quick, fetch me my brown trousers . . ."

The nurse from the American Cancer Society had just lectured to a group of colostomy patients on sexuality. During the ensuing question and answer period, a disappointed patient complained, "I thought you were going to show us how to have more fun with our colostomies . . ."

An ardent golfer was getting on in years and had a burning question . . . He sought the help of a spiritualist . . . "I want to know if there are golf courses in Heaven." The spiritualist held a seance and summoned the spirits . . . He then turned to the aging golfer and said, "I have good news and bad news. Let me tell you the good news . . . Yes, there are gorgeous golf courses in Heaven." "What's the bad news?" "You have a starting time for this Sunday morning." (As told by **Bill Moore**)

In the "Cactus Flower" the bachelor dentist (Walter Mathau) tells his girl friend (Goldie Hawn) that he has a son

12 years old . . . "But you told me you were married 10 years." Walter quipped, "Oh, he was a premature infant." (Gleaned from TV)

Hors De Combat

Two medical offices in Kona were burglarized in Feb. . . . **Wilmot Boone** reported money and drugs worth \$730 stolen and **Frank Ferren** of the Kona Coast Group reported a cash box with \$30 stolen . . .

In December, the Waimea Dispensary was broken into and a fetal heart monitor and a small pocket computer were stolen. In January, W.H. Palmer of Pahoa, Hawaii wrote in the Reader's Forum, Hawaii Hilo Tribune, that he has been burglarized 4 times in the past 6 weeks and that his pharmacy has been reduced to nothing . . . "The police have asked me to be patient, but I'm being forced out of business . . . I'm not local and maybe that is my problem . . . I don't know . . ."

Stephan Tenby, a Hawaii Kai resident, is waging a life and death battle to get the city to provide around the clock ambulance service in Hawaii Kai . . . (The nearest ambulance is in Wailupe and the nearest emergency room at QMC) "It's my major battle . . . We're talking about people's lives and their deaths," he declares grimly . . .

The hearing officer for the State Board of Medical Examiners recommended the revocation of psychiatrist **C. Stanard Smith's** medical license for improperly prescribing amphetamines, barbiturates and narcotics between 1973 and 1976 while in private practice in Hilo . . . Circuit Court Judge Arthur S.K. Fong ruled that the three court appointed psychiatrists **Richard Kemble**, **Darins Amjadi** and **K.Y. Lum** who recommended Paul Luiz's supervised release in 1974, are immune from civil charges of negligence. Paul Luiz, 30, as you recall, stabbed to death a 16 year old Hawaii Kai student, Barbara Seibel, in 1976 and her parents filed a \$700,000 suit last September . . .

Tel Med Report . . .

Tel Med (Phone 521-0711) is open Monday to Friday from 12 noon to 8 p.m. and averages 6,000 calls a month . . . The most popular tapes are as follows: 1050-Male Sex Response; 898-Female Sex Response; 137-Marijuana; 12-Am I Really Pregnant?; 8-Veneral Disease; 67-Warning Signs of Pregnancy; 15-Syphilis; 1180-Homosexuality; 16-Gonorrhea; 25-Hypertension and Blood Pressure; 147-The Lady Living Alone; 42-I'm Just Tired. The following are subjects requested, but as yet unavailable: Rheumatic Fever, Strep throat, measles, sinuses, allergies, goiter, heroin, tumors, hepatitis, liver ailments . . .

Our "Angels"

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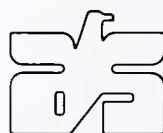
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Hawaii MEDICAL JOURNAL

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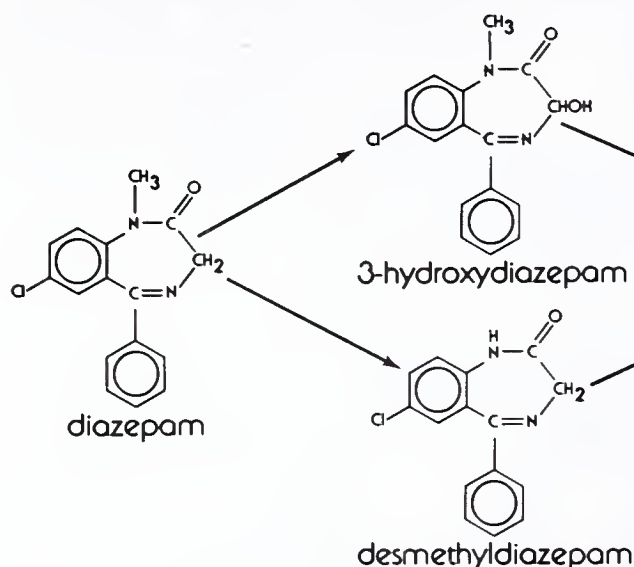
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memo

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A dramatic, low-key photograph of a woman's upper body. She is shown in profile, looking down with a somber expression. Her right hand, with red-painted nails, is gently touching a patch of irritated, red, and inflamed skin on her left shoulder. The background is dark and textured, possibly a wall or a large object, which adds to the moody and clinical atmosphere of the image.

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Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

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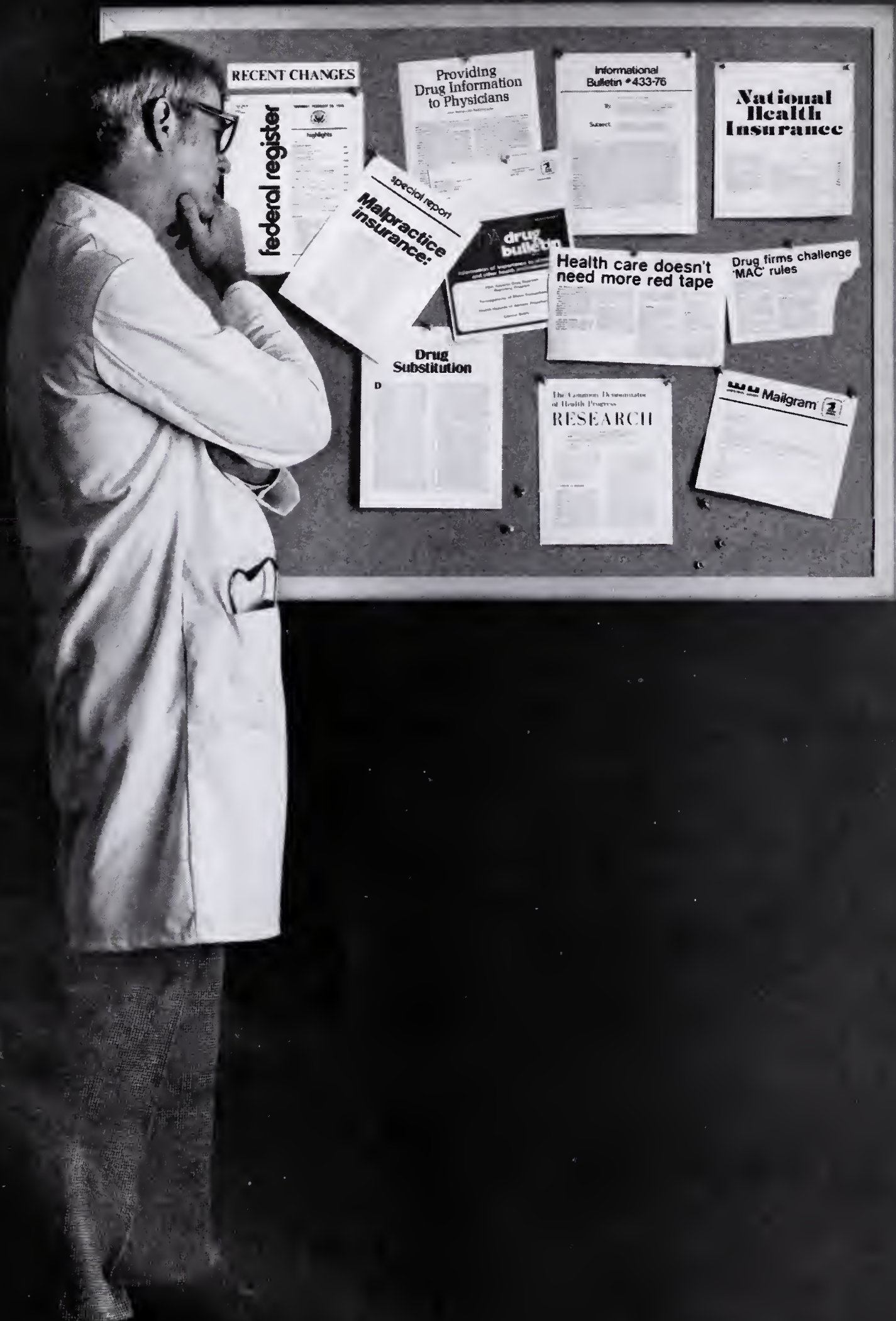
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Drug Substitution

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Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

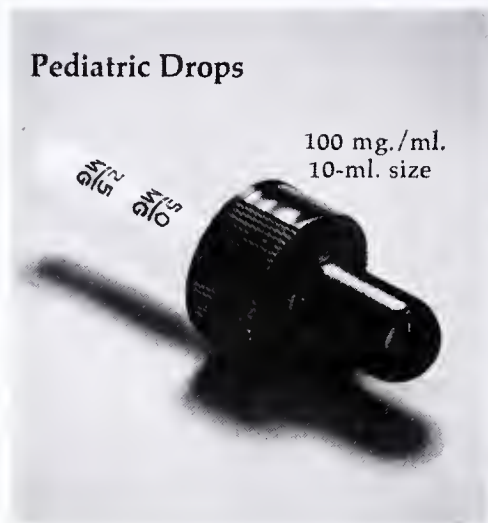
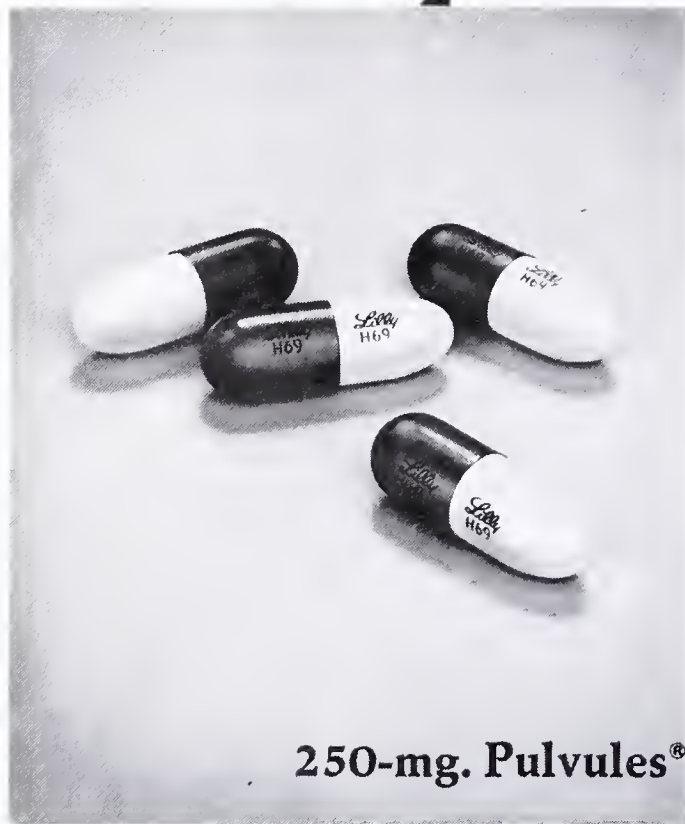
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Leptospirosis in Hawaii

W. A. SHRADER, JR., M.D., *Big Island*

● *Leptospirosis, known variously as Weil's Disease, canicola fever, swineherd's disease, and infectious jaundice, is a disease of world-wide distribution. Approximately 70 to 80 cases per year are reported from all regions of the United States; a substantial percentage of these cases (average 10-11%) occur in Hawaii (Table 1).*

The disease is considered "uncommon," and probably goes highly unrecognized in most areas, including Hawaii, because of its relative rarity and lack of a "high index of suspicion" among physicians. Suspicion is ever present, however, on the Hamakua coast of the Big Island (Hawaii); here the disease must be considered frequently, due to the proximity of endemic

areas. Of the cases of leptospirosis reported from the Island of Hawaii from 1962-1975, 42% have occurred here, many relating to exposure to Waipio Valley.

Epidemiology

Leptospirosis is primarily a disease of lower animals, caused by the spirochete of the genus *Leptospira*. Of the 130 serotypes and subserotypes known, man is susceptible to incidental infection by at least 14.¹ Man may become infected through direct contact with an infected animal, or more commonly, through contact with water contaminated by the urine of infected animals.

TABLE 1.—*Leptospirosis, State of Hawaii, by Counties 1960-1975*

YEAR	STATE	HAWAII	OAHU	KAUAI	MAUI (MOLOKAI, LANAI)
1960	3	1	2	0	0
1961	4	4	0	0	0
1962	11	7	3	1	0
1963	26	21	4	1	0
1964	13	11	2	0	0
1965	8	8	0	0	0
1966	19	17	2	0	0
1967	8	7	1	0	0
1968	11	9	2	0	0
1969	8	7	0	1	0
1970	1	1	0	0	0
1971	0	0	0	0	0
1972	4	2	2	0	0
1973	1	0	0	1	0
1974	8	2	3	3	0
1975	3	3	0	0	0
TOTAL	128	100	21	7	0
% of TOTAL	100%	78%	16%	6%	0%

*Accepted for publication May, 1976.

A large variety of animals have been found to carry the disease, among them rats, dogs, cattle, swine, sheep, goats, horses, bats, shrews, jackals, hedgehogs, opossums, racoons, skunks and foxes. There is no reason to believe the disease cannot be contracted and transmitted by many more domestic or wild animals. Even arthropods, namely ticks, have been found to transmit the disease.²

The leptospira usually enter the body through mucous membranes of conjunctivae, nose or mouth, or through skin abrasions or lacerations. It has been demonstrated that leptospira may survive several weeks in moist soil, stagnant ponds, or slow-moving streams which are neutral or slightly alkaline, providing the temperature is 71.6° F or above.³ The incubation period in the human seems to average approximately 10 days.

**Leptospirosis Case Reviews,
Honokaa Hospital**

Nineteen patients with serum positive leptospirosis admitted to Honokaa Hospital from 1962 through 1975 are reviewed. It should be noted that only these patients were deemed ill enough to require hospitalization; the majority of patients with the disease were treated as outpatients.

Presenting signs and symptoms are enumerated in Table 2. In addition, 84% of the patients demonstrated albuminuria, 47% had increased serum bilirubin or bile in the urine, and 11% had pneumonia. Shortly before their hospitalization, 63% of the patients either lived, worked, or had been in Waipio Valley. One patient (5%), age 70, expired of the disease.

The average of the high oral temperatures recorded was 102.5° F. Average WBC was 8,200, though all patients demonstrated a mild to moderate left shift. Serum SGOT was performed on five patients, and was elevated in three.

Discussion

The most reliable diagnosis of leptospirosis is made by serologic testing. Antibodies appear between the sixth and twelfth days of illness.

Leptospirosis is usually a self-limiting disease, and occurs in two phases. The acute or systemic phase lasts approximately one week, during which time the leptospiral organisms are most commonly recovered from the blood and cerebrospinal fluid. (The average length of stay of patients reviewed at Honokaa Hospital was 5.9 days.)

The second, or immune phase lasts up to two weeks, during which time fever may return to a milder degree and leptospiral serum antibodies increase.⁴ Initial serologic testing may be negative, as was the case in several of the patients reviewed in this study, and the importance of serologic testing two to three weeks after the onset of the illness cannot be overemphasized. Also of note is the fact that during the immune phase, patients excrete leptospira in the urine.⁴ This may be a factor in the transmission of the disease, as carrier states have been observed up to several months in humans.⁴

Leptospirosis is seldom fatal, though factors such as advanced age, debility, and organism virulence seem to play a role in the severity of the disease. The cause of most deaths seems to be advanced hepatorenal involvement. The one pa-

TABLE 2.—*Clinical Signs & Symptoms Observed in Patients Admitted to Honokaa Hospital, 1962-1975 with Serum Positive Leptospirosis.*

SIGN OR SYMPTOM	NO. OF PATIENTS	% OF PATIENTS
Fever	19/19	100%
Nausea and/or Vomiting	12/19	63%
Headache	11/19	58%
Malaise	9/19	47%
Chills	8/19	42%
Anorexia	8/19	42%
Myalgia	7/19	37%
Dizziness	7/19	37%
Jaundice	6/19	32%
Leg Pains	5/19	26%
Scleral Injection	4/19	21%
Abdominal Pain	3/19	16%
Cough	2/19	11%

TABLE 3.—Seasonal Occurrence of Leptospirosis in the Mongoose in Waipio Valley. From Tomich³

MONTHS	JAN. FEB.	MAR. APR.	MAY JUNE	JULY AUG.	SEPT. OCT.	NOV. DEC.
Percent of Animals Tested Found to be Infected.	34	34	22	5	18	13

tient who expired in this study died of massive sepsis with bacterial endocarditis and hepatic and renal abscesses.

Treatment of the disease remains controversial, primarily because not enough cases occur at the same time or location to permit controlled studies. Many antibiotics, including penicillin, streptomycin and tetracyclines have been employed, but results are questionable. However, there is suggestive evidence in both animals and humans that administration of antibiotics in high doses, if given within 48 to 72 hours of onset of symptoms, is beneficial in reducing the severity of the illness.^{5,6}

Of the patients studied at Honokaa Hospital, 17 of 19 (89%) received a variety of antibiotics, including oxytetracycline, cephalothin, lincomycin, tetracycline, cephaloridine, penicillin, alone and combined with streptomycin, chloromycetin, cefazolin, and cephalexin. The patients who received antibiotics became afebrile in an average of 4.8 days. In the two patients who did not receive antibiotics, fever persisted for an average of 7.5 days. However, these figures may not be statistically significant. It should also be noted that the one patient who expired had received antibiotics throughout his hospital stay, a total of 10 days until his death.

Waipio Valley Endemicity

Dr. P. Quentin Tomich has written a most thorough and interesting paper dealing with the epidemiology of leptospirosis in Waipio Valley.¹ His study included the mongoose, house mouse, Norway rat, roof rat, and polynesian rat. He found 21-31% of the mongooses studied to be infected (*L. Icterohemorrhagiae*, *L. Sejroe*), as high as 33% of the mice (*L. Ballum*, *L. Icterohemorrhagiae*), 50% of Norway rats (*L. Icterohemorrhagiae*), 55% of roof rats (*L. Icterohemorrhagiae*, *L.*

Ballum), and up to 34% of polynesian rats (75% *L. Icterohemorrhagiae*). Thus the endemicity of leptospirosis in Waipio certainly goes without question. Since only 3 of the 44 patients having been in Waipio Valley had known exposure to the animals studied above, it can be assumed that the rest of the patients had contact with either infected urine or other animals carrying the disease, probably primarily the former.

Dr. Tomich found that the infection rate among mongooses was distributed seasonally as shown in Table 3. Highest prevalence was found in January through April. However, our data (Table 4), suggest that the highest prevalence in humans occurs in the summer months of May through July. The reason for this difference is not clear at this time; perhaps study of the seasonal occurrence in other animals may clarify this.

Conclusion

Leptospirosis is endemic in the state of Hawaii. Though uncommon in humans and only occasionally fatal, it should be considered in any febrile illness characterized by gastrointestinal disorder, headache (usually frontal), myalgia, malaise and chills. The presence of urinary abnormalities, contact with domestic or wild animals, or contact with any fresh water source frequented by rodents or domestic animals should arouse suspicion.

Acknowledgements

I would like to thank Dr. A. P. Sackett, District Health Officer, Hawaii Dept. of Health (Hilo); Dr. P. Q. Tomich, Animal Ecologist, Hawaii Dept. of Health (Honokaa), and Chester Wakida, Epidemiological Specialist, Hawaii Dept. of Health, whose help made this paper possible.

TABLE 4.—Seasonal Occurrence of Human Leptospirosis in the State of Hawaii.

MONTHS	JAN. FEB.	MAR. APR.	MAY JUNE	JULY AUG.	SEPT. OCT.	NOV. DEC.
Percent of Cases in the State	11	11	29	19	16	14
Percent of Cases with Known Contact with Waipio Valley	11	11	29	28	7	14

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A review of ischemia in the extremities . . .

Clinical Assessment of Chronic Occlusive Peripheral Arterial Disease

IRWIN J. SCHATZ, M.D.,* *Honolulu*

● *There are few symptom patterns more specific than those caused by chronically diminished blood flow to the extremities. Manifestations of ischemia include intermittent claudication, rest pain, neuropathy, ulceration and gangrene; they are easily recognized from the patient's history. Physical examination will determine the degree of ischemia present and the approximate level of the occlusive process. A decision about therapy will not require laboratory aids and often may be made at the time of the initial visit. Such relative simplicity in the modern practice of medicine is refreshing but rare. This paper will outline clinical features of chronic occlusive arterial disease which may be detected at the time of the patient's first visit to the physician.*

By far the most common cause of inadequate arterial flow to the limbs is atherosclerosis of the large arteries. What follows is a description of patients with symptomatic atherosclerotic peripheral vascular disease. Subsequently, a brief discussion of the clinical findings in non-atherosclerotic occlusive disease will be presented.

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University of Hawaii, Honolulu, Hawaii

Accepted for publication February, 1976.

Lower Extremity

SYMPTOMS

Symptoms of ischemia in the lower extremity are relatively specific. Although some patients may be vague in their description of discomfort, brief but careful questioning by the physician will usually discern definite patterns.

The most common complaint caused by arterial insufficiency in this area is intermittent claudication. By strict definition, this means discomfort, ("pain, cramping, heaviness, tiredness") in the calf, occurring on exertion and relieved promptly by rest. The same symptom may exist in the low back, buttocks, hips, thighs, instep, and the arches, and may also be called claudication. The characteristic onset with walking and prompt relief with rest in one or two minutes (or sometimes merely upon slowing the pace), is one of the most specific patterns in clinical medicine. It should not be confused with other causes of pain in the legs. It does not occur when the patient lies, stoops, bends, or sits, and only rarely will be observed after prolonged standing. It must be differentiated from nerve root compression syndromes, which on occasion mimic claudication, and from musculoskeletal disturbances of the feet, which can be confused with claudication of the arches.

When hypoxia of the subcutaneous tissue and skin progresses, ischemic rest pain will result. Patients complain of a nagging, burning, or aching discomfort in the toes or in the instep. This symptom is unusual above the ankle and is always most severe in the distal part of the extremity. It is particularly troublesome at night, preventing sleep. Relief will sometimes be obtained by dangling the foot over the edge of the bed, or by walking a few steps. Nerve root compression syndromes will sometimes produce similar symptoms, but differentiation will become clear after physical examination.

Ischemic neuropathy has characteristics similar to rest pain, but may be more lancinating in nature, and only momentarily present on occasion. It is caused by hypoxia of peripheral nerves and has the same prognostic significance as ischemic rest pain.

Ischemic ulcerations, whether spontaneous or traumatic, usually occur in the distal part of the foot. The pain of ulceration may be exquisite, necessitating control with narcotics. Gangrene, on the other hand, is sometimes painless.

Symptoms of ischemia will almost always be present as one or more of these four clinical patterns. If they do not generally fall into these categories, then careful search for another source of the patient's complaints must be made.

SIGNS

If occlusive arterial disease is sufficiently severe to produce symptoms, the physical stigmata of ischemia may be detected easily by the discerning physician. On observation of the patient, the practitioner will note the presence of any ulceration, the color of the skin, and the size of the limb. Ischemic ulcers only rarely occur above the ankle. They are characteristically present on the toes and usually have an infected necrotic base with poorly nourished and erythematous surrounding skin.

If rest pain is present, the foot is usually pale and has atrophic skin and scant hair growth. There may be evidence of healing or healed ulceration.

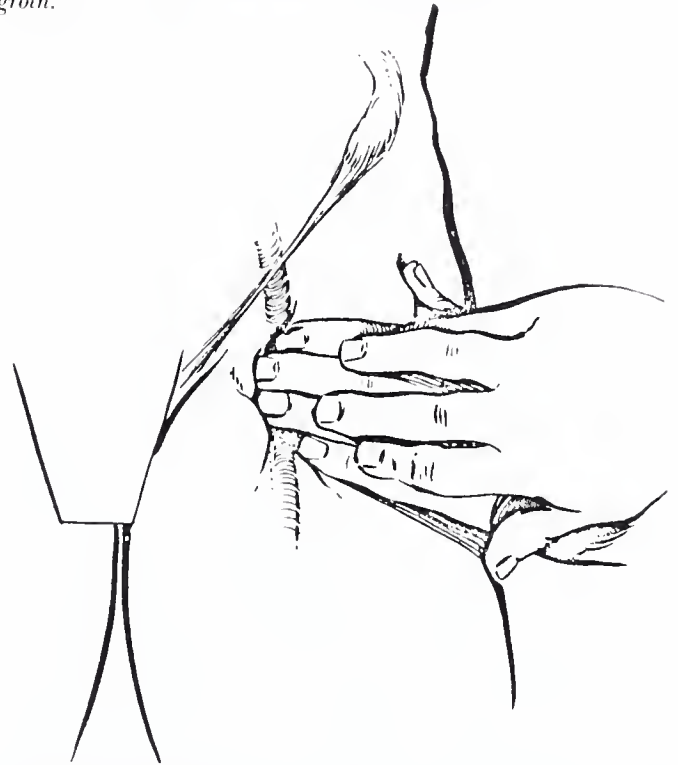
In patients with long-standing intermittent claudication, careful observation will reveal a distinct difference in size of the calves because of atrophy of the large muscle groups on the ischemic side.

Petechiae may be scattered over the sole of the foot or the toes. Such lesions are produced by sudden obstruction of arterial flow to the extremity, but can persist well into the stage of chronic severe ischemia.

In feet which are moderately ischemic, there is usually a difference in temperature upon palpation. In addition, some hypesthesia may be noticeable in the skin of moderately-to-severely ischemic feet. Testing of sensation should not be done with a pin or other traumatic instrument which might inadvertently puncture the skin.

Palpation of the pulses is the most important part of the examination of patients with occlusive arterial disease, since it will indicate to the examiner the approximate location of the obstructive process. The femoral artery is easily felt in most patients, even the most obese. Direct-

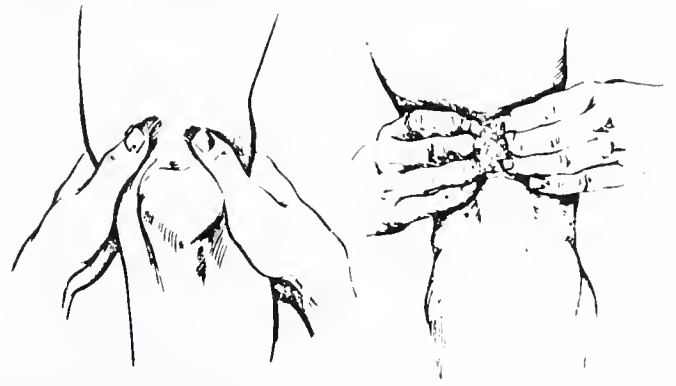
FIGURE 1.—An acceptable method for palpating femoral artery in groin.



ing one hand with the other is of value in avoiding misinterpretation. (Fig. 1). Posterior tibial and dorsalis pedis pulses are not difficult to feel in most people. In approximately 5 per cent of normal individuals, however, the dorsalis pedis pulse may be absent because of anatomical variation.

The most difficult pulsation to feel in the lower extremity is that of the popliteal artery. (Fig. 2).

FIGURE 2.—Palpation of popliteal artery pulsation: The knee is slightly flexed, and the fingers of both hands are pressed deeply and firmly into popliteal space.



The four fingers of each hand are placed in the popliteal space, as outlined, and firmly pressed into this area. The pulsatile popliteal artery imparts a rather diffuse sensation, unlike the more discrete pulsation felt in the femoral or posterior tibial areas. It is palpable in all patients who have a normal popliteal artery and should be searched for in any patient who has symptoms of ischemia in the lower extremity.

The localization of the occlusive process may be deduced from the findings on examination: (Table 1).

TABLE 1.—*Presence or absence of pulsations is used to determine site of occlusion.*

Area of Occlusion	Pulsations*			
	Aorta	Femoral	Popliteal	Ankle**
Aorta-Iliac	P or A	A	— +	— +
Superficial Femoral	P	P	A	±
Infra-Popliteal	P	P	P	A

* P = pulsation normal or minimally diminished
A = pulsation absent
± = pulsation absent or markedly diminished
** = Posterior Tibial and Dorsalis Pedis

1. If the aortic pulse is palpable but the femoral pulse is not present, then an occlusion exists in the aorto-iliac system on the involved side. Occasionally, collateral supply will create sufficient blood flow distal to an iliac artery occlusion to produce a discernible pulse in the popliteal and ankle vessels. The presence of these pulses and the absence of a femoral artery pulsation is quite compatible with a partial or complete occlusion of the aorto-iliac segment.

2. Normal aortic and femoral pulses and absent popliteal and ankle pulses indicate obstruction in the superficial femoral artery segment, with or without infrapopliteal arterial occlusion. In this situation, it is difficult to determine if significant atheromata are present in any or all of the three branches of the popliteal artery, or whether the occlusion is confined solely to the superficial femoral artery. Generally speaking, those patients with severe ischemia (rest pain) who have these findings will have occlusions in both the superficial femoral and at least two of the three branches of the popliteal artery. Occasionally, an absent popliteal artery pulse may be accompanied by a normal femoral artery pulsation and a weak but distinctly palpable posterior tibial or dorsalis pedis pulsation, since sufficient patent collateral vessels exist to carry enough blood to cause pulsation in the ankle vessels.

3. Normal aortic, femoral, and popliteal artery pulsations and absent ankle pulses indicate infra-popliteal arterial occlusive disease. One or both of the ankle pulses may be absent, although an absent dorsalis pedis artery, as already stated, may be merely an anatomic variation.

The importance of adequate palpation of the pulses cannot be overemphasized; decisions about subsequent surgical intervention should be made at this time. These judgments will depend upon the physical findings and the physician's presumptions as to localization of disease.

POSTURAL TESTS

Assuming that ischemic symptoms are present and localization of the obstruction has been de-

termined, the degree of ischemia is assessed by postural testing:

1. Elevation pallor: Both feet are elevated to 80° with the patient lying recumbent. Patient is asked to flex and extend the foot vigorously at the ankle in order to empty the foot of blood. After 60 seconds of such activity, the degree of pallor that is present in the sole of the foot is estimated by the examiner. The amount of ischemia may be graded on a 0-3 basis and if the contra-lateral foot is not ischemic, comparison with it is made. Such determinations may then serve as a baseline for future examinations.

2. After the amount of elevation pallor has been gauged, the patient is asked immediately to sit up and let his feet hang down over the edge of the examining table. The physician notes the exact time, and then determines when the veins on the dorsal aspect of the foot fill with blood. This is called the "venous fill time" and normally should be no more than 15 seconds from the time of assuming the upright position. In the presence of occlusive arterial disease, the delay in venous fill time may extend up to 60 seconds or more. If incompetent varicose veins are present, there will be retrograde filling of the superficial veins of the foot, and the test is nullified.

3. Normal color will return to the foot after assuming the upright position in approximately five seconds. If arterial insufficiency is present, the color return, (filling of the capillaries) may be delayed and will roughly parallel the degree of ischemia.

4. Sixty seconds after assuming the upright position, the amount of dependency rubor in the toes is noted. Ordinarily, only mild rubor is present in normal patients. The degree of rubor varies directly with the amount of ischemia present.

From the accumulated data derived from palpation of the pulses and postural testing, an accurate judgment can usually be made about the level of occlusion and the severity of ischemia.

Auscultation over the aorta as well as over the femoral arteries should be performed. Bruits are heard almost invariably in patients with significant atherosclerosis, but the presence of such sounds in the absence of other findings should not be interpreted as indicating severe disease. These signs are considered corroborative only.

The following case description is an example of the usefulness of careful analysis of the history and examination in the assessment of patients with occlusive arterial disease:

A 47-year-old assembly line worker complained of cramps occurring in the right calf after walking half a block, promptly relieved by rest. This symptom had been present for two years and had become somewhat worse recently. In the week preceding the examination, he had noticed mild burning in the great toe of his right foot at night. He was otherwise asymptomatic.

On examination, the right calf was slightly smaller in circumference than the left. The toes on the right foot were cooler, paler and less hairy than on the left. Aortic and right femoral artery pulsations were normal, compared with the left. A soft systolic bruit was heard over the femoral artery on the right, and the popliteal and dorsalis pedis arteries were not palpable. A faint pulsation was felt in the right posterior tibial artery. There was Grade I elevation pallor of the right foot when compared with the left and Grade II dependency rubor. The venous fill time on the right was 45 seconds and on the left, 12 seconds. Color return was delayed 20 seconds on the right, 5 seconds on the left.

A diagnosis of right superficial femoral artery atherosclerotic occlusive disease was made, with moderate ischemia of the right foot with incipient rest pain. At the initial visit, aortogram or right femoral arteriogram was recommended, to detail the occlusive lesion in the right superficial femoral artery, since symptoms were sufficiently severe to warrant reconstructive arterial surgery. The lesion was considered by the vascular surgeons to be correctable surgically, and a femoropopliteal bypass operation was performed.

In this case, intermittent claudication in the calf was classic. The recent progression of symptoms and appearance of rest pain indicated either propagation of the obstructive process in the main artery or recent occlusion of some collateral channels. The presence of rest pain was ominous, indicating definitive therapy. Absence of the popliteal pulse and presence of a faintly palpable posterior tibial pulse pointed to a reasonably good outflow from the popliteal artery distal to the occluded segment of the superficial femoral artery. Presence of moderate ischemia on postural testing was consistent with the presence of ischemic rest pain.

Upper Extremity

Atherosclerosis of the major arteries in the upper extremity is probably less common and certainly less symptomatic than in the lower extremity. Significant occlusion of the subclavian and axillary arteries may occur without any symptoms. When complaints do appear, they usually first consist of a feeling of coldness in the hands, with or without the appearance of Raynaud's phenomenon in the fingers. Occasionally, claudication of the hand, wrist, or forearm after heavy work will be present.

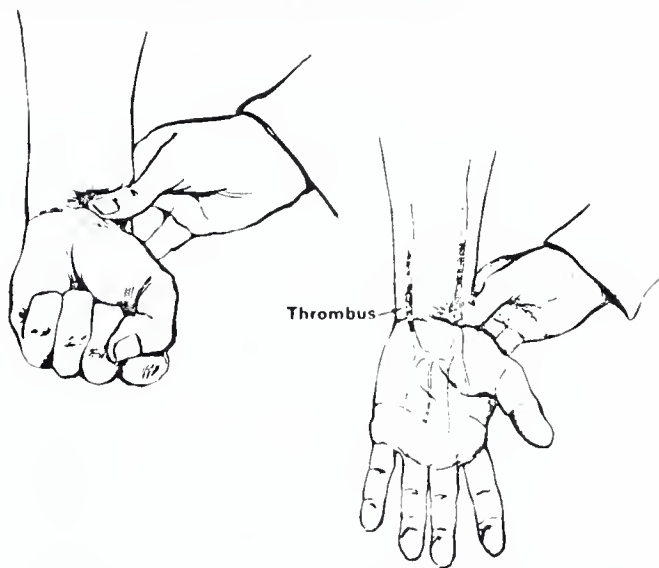
Palpation of the radial, ulnar, brachial, subclavian, and carotid arteries should be attempted. It is particularly important to attempt to palpate the ulnar artery since absence of this pulse indicates significant occlusive disease in that vessel. (Fig. 3). Allen's test is used to determine whether there is decreased flow through the ulnar artery

FIGURE 3.—Ulnar artery pulsation is detected by flexing the wrist slightly and palpating just lateral to the distal ulna.



into the hand. As indicated in Fig. 4, the radial artery is firmly compressed by the examiner's thumb, and the patient is asked to repeatedly clench and unclench his fist in order to empty the palm of blood. Normally, flow through the ulnar

FIGURE 4.—Allen's test: After emptying the palm of blood by clenching the fist and occluding the radial artery, the palm remains pale after unclenching because of thrombosis of ulnar artery. If ulnar artery is not obstructed, palm becomes pink.



artery should cause the palm of the hand to become pink, filled with blood, in a matter of one or two seconds after the fist is unclenched. If there is a delay in color return to the palm, or if the palm remains quite pale, this is presumptive evidence of significant occlusion of the ulnar artery or that part of the palmar arch supplied by the ulnar artery. Testing radial patency may be made in a similar way by compressing the ulnar artery.

Examination of the brachial pulsation in some people is impossible because of large muscles. Brachial blood pressures equal on both sides presumes equal flow. Auscultation over the subclavian artery in the supraclavicular space as well as over the carotid artery is important to confirm atherosclerosis, but conclusions from the presence of bruits there should not be made, except in the presence of significant symptoms or diminished pulsations.

Postural testing of the hands is performed by asking the patient to elevate his hands and clench and reclench the fists several times. Normally, there should be sufficient arterial inflow into the elevated hand to retain a pink color. If there is pallor on elevation, ischemia is present.

Non-atherosclerotic Occlusive Arterial Disease

LOWER EXTREMITY

From a practical viewpoint, arterial insufficiency in the lower extremity not due to atherosclerosis is confined to segments of the arterial tree distal to the popliteal artery. The same situation obtains in the upper extremity, with the important exception of those conditions which chronically or intermittently obstruct the subclavian artery in the neck, such as cervical ribs and thickened scalenus anticus muscles.

A comprehensive review of various forms of small vessel occlusive arterial disease in the extremities will not be made here. However, ischemia, no matter from what cause, can declare itself in only one of several limited ways. Consequently, the symptoms and signs of ischemic distal extremities will be similar, no matter what the etiologic process is.

SYMPTOMS

Intermittent claudication of the lower part of the calf and the arch of the foot occasionally may occur as a result of occlusion of the infrapopliteal segments. This may be a result of so-called senile arteriosclerosis which is differentiated from atherosclerosis by absence of atheromata in the obstructing lesions, and the presence of significant medial calcification. Similarly, Buerger's disease (thromboangiitis obliterans) commonly affects these vessels and causes intermittent claudication. Ischemic rest pain and ischemic neuropathy due to these processes have no differentiating characteristics from those due to atherosclerosis. When rest pain is restricted to one digit, however, occlusive processes in the more distal vessels are a likely cause. This is particularly true in patients with chronic rest pain due to embolic or thrombotic digital arterial occlusion. Similarly, young men with thromboangiitis obliterans will often present with severe rest pain in one toe as a result of digital artery obstruction in that area.

Pain associated with ulceration due to thromboangiitis obliterans is usually severe and incapacitating; large doses of narcotics are necessary for effective control. Apart from this, these ulcerations have no distinguishing features from those caused by atherosclerosis. Ulcerations due to diabetic vascular disease often occur at the heel and may be painless if significant diabetic neuropathy is present.

SIGNS

The observation of one cyanotic or pale toe in the presence of normal fellow toes indicates a

specific occlusive process occurring to the arterial circulation in that toe. Clinical demarcation of normal from ischemic zones in the foot usually indicates obstruction of small vessels in the foot. When ischemia is due to an occlusive process in a proximal artery of the limb, the entire foot will share in the ischemic manifestations.

Occasionally, digital arteries may be felt as faint paired pulsations at the base of the digits. The absence of such pulses, however, may merely reflect the examiner's inability to feel them.

Upper Extremity

Symptoms and signs of small vessel occlusive disease in the upper extremity are similar to those which have been discussed for the foot. The presence of a cold, pale, or cyanotic finger in the absence of signs of ischemia in the other fingers clearly indicates a local disturbance of circulation. In traumatic arterial disease, thickening of the fascia of the palm of the hand, together with signs of localized sclerosis of the skin of the fingers (sclerodactyly), may be a clue to the presence of obstruction to the vessels in those areas. Raynaud's phenomenon is very often an important manifestation of organic occlusive arterial disease in these small vessels and a diagnosis of Raynaud's disease must not be made unless a thorough search for a secondary cause has been fruitless.

Thoracic outlet maneuvers are utilized to detect any possible obstruction to the subclavian artery in the neck. Adson's maneuver consists of palpation of the radial artery while the patient's head is fully extended, rotated to the right, and then to the left with a simultaneous full inspiration. Diminution or disappearance of the radial pulse is an indication of obstruction of the subclavian artery. Occasionally, a cervical rib may be palpated in the supraclavicular space. Poststenotic dilatation of the subclavian artery distal to a thickened scalenus anticus muscle or a cervical rib may be palpable; occasionally a bruit may be audible over such an area of dilatation.

Summary

Because of the specificity of symptoms caused by chronic ischemia of the limbs, and the ease with which physical signs are detected, a diagnosis of occlusive arterial disease in the extremities is one which almost always can be made at the bedside or at the examining table. The physician who performs a careful history and physical examination in these patients will be rewarded with sufficient clinical information so that specific judgments about therapy may be made at the initial visit.



JON WON

HMA President Cal Sia visited May 17th with Maui County Medical Society at its monthly meeting and gave the Maui members a brief update on the activities, challenges, and opportunities of the HMA. The HMA and Dr. Sia very much appreciate the hospitality given by the Maui physicians and their spouses.

The Hiroshima Medical Society has recently sent representatives to the Atomic Bomb Commission on the mainland and has been hosted by the HMA on their return to Japan. The Hiroshima Medical Society presented the HMA a gift of friendship—a replica of a golden samurai warrior. The representatives of the Hiroshima Medical Society would like to establish a formal relationship with the HMA and has asked if the HMA would adopt such a resolution. If such a resolution is adopted, the Hiroshima Medical Society would very much like to have a contingent of HMA representatives to present such resolution to the Hiroshima physicians in Japan.

HMA will be well represented at the 126th Annual Meeting of the AMA in San Francisco, June 18-23, 1977. We have found it well worthwhile for all Hawaii physicians attending AMA meetings on the mainland to get together during the meetings. If any of you HMA physicians are planning to attend this San Francisco meeting, please let us know when you will be there and where you will be staying. We would like to try to get together in San Francisco.

HMA's Delegate to the AMA, Dr. George H. Mills, is a candidate for election to the AMA Board of Trustees at this San Francisco meeting. The leadership of the AMA is in full support of Dr. Mills' candidacy and the HMA will be hosting a reception in San Francisco for Dr. Mills on Tuesday, June 21, 1977, from 7:30 to 9:00 p.m. at the Fairmont Hotel. Let's all pull for Dr. Mills!

AMA is pleased to report that the U.S. House Commerce Committee has deleted entirely from HR 3816, Section 14(A)(1), language that would have specifically brought non-profit associations, including medical organizations, under the jurisdiction of the Federal Trade Commission.

AMA wishes to advise physicians that it has received a past postage bill of about \$1 million from the U.S. Postal Service and is now conducting a technical review of the claim. In August, 1975, the AMA voluntarily and formally informed the Postal Service that the AMA had not observed correct practices in reporting on two forms used in mailing publications at a special second class rate . . . The postal rate error was innocent. There was no intent to deceive or defraud. Having brought the matter to the attention of the Postal Service, the AMA said the practices (of which AMA top management had not been aware) had been corrected.

Georgia Institute of Technology announces a special course in sampling and statistical design of interest to physicians. The course, "Statistical Design and Analysis for Decision Making," will be held July 11-15, 1977, and is designed to prepare the practitioner with appropriate statistical tools for analyzing data from both planned and unplanned experiments, including statistical model building. Interested physicians contact Mr. George Adams, Dept. of Continuing Education, Georgia Tech, Atlanta, Georgia 30332.

Joint Conference of the American Association for Automotive Medicine and the VII International Association for Accident and Traffic Medicine will be held July 10-15, 1977, in Ann Arbor, Michigan. Interested physicians contact the HMA office for more details.

Hickam AFB is recruiting a Medical Officer (Pediatrics). The position is full time in U.S. Civil Service with accompanying benefits. Interested physicians address inquiries to Civilian Personnel Office, 15 Air Base Wing/DPCC, Hickam AFB, Hawaii 96533, telephone 449-6733.

Air Force Medical Center at Wright-Patterson AFB, Ohio, announces recruitment to fill a civilian vacancy for a Medical Officer (General Practice). Interested physicians can get more details at the HMA office.

Primary Care Center in Honolulu now recruiting two (2) physicians for positions of Medical Director and Primary Care Practitioner. Should be board certified/eligible internists or family physicians. Outstanding opportunity to provide innovative health services with emphasis on preventive care. To start approximately July, 1977. Interested physicians send curriculum vitae to

Director of Primary Care, St. Francis Hospital, 2230 Liliha St., Honolulu, Hawaii 96817.

On Kauai, needed are internist, pediatrician, general practitioner, and E.R. physician for expanding quality-oriented and accredited 25-physician group practicing in modern, non-profit hospital-affiliated outpatient facility. Competitive starting compensation. Malpractice insurance coverage provided. Full stockholder status eligibility after 2 years; 4 weeks paid vacation plus 2 weeks scientific meetings and travel reimbursement, disability and life insurance, tax-sheltered pension plans, etc. Senior physicians encouraged to apply. Correspond with Administration, Kauai Medical Group, Inc., Lihue, Kauai 96766.

Why Physicians should participate in political action (HAMPAC & AMPAC)

In a recent address to providers of health care representing the medical, pharmaceutical and nursing professions of Hawaii, John H. Schriever, Vice President of Lederle Laboratories stressed the importance of health professionals being involved in the legislative process. "If physicians are to best serve the citizens of America and to maintain the high standards of American medicine then it is up to physicians as well as other health professionals to insure that the voice of the health professionals is heard in determining their own future. Some, to be sure, are better prepared to write legislation than we. But if legislation is to affect our professional standards, then let us take our place among the legislators."



AMPAC's immediate past president Dr. James MacLaggan lets AMPAC's views be known to Hawaii's senior Senator Daniel Inouye and Dr. Calvin Sia, President of the Hawaii Medical Association, and a sustaining member of AMPAC and HAMPAC.

"We must stand up and be counted," Schriever continued. "We must learn to challenge government as they challenge us. The assumption made whenever a government agency meddles in the private sector is that those involved are no longer capable of controlling themselves in the best

interest of the community. Physicians, pharmacists and other health professionals have come under the spotlight of government. The results so far appears to account for an increased level of paper work rather than improved health care."

Every physician therefore should join a political party of their choice; join HAMPAC and AMPAC; contribute time to precinct work and candidate support; contribute financially to their party and candidate of choice both individually and through HAMPAC. These words of advice were echoed by United States Senator Dan Inouye and State of Hawaii Representative Lisa Naito at the HAMPAC-AMPAC Workshop held earlier this year in Honolulu for physicians and their families. If you are not already a 1977 member of HAMPAC and AMPAC call or write to Leonard Howard, M.D. HAMPAC Chairman, 320 Ward Avenue, Suite 200, Honolulu, Hawaii 96814 and an enrollment form will be furnished.



. . . people pressures

National and local news media lately have had much to say about rising costs of hospitalization. President Carter himself has spoken on the need for Congress to devise some method to put a ceiling on hospital charges.

The remedy for a pot that is boiling over is not to put the lid on, but to turn the burner down.

Placing the *onus* on the attending physician is to misdirect attention to a minor part of the problem. The proof of this lies in the failure of "PSRO" and of "Certificate of Need" to lower the costs of medical care in general. These mechanisms, in fact, have undoubtedly added to the costs.

The fact of Third Party fiscal coverage is a much larger factor in all this, and not the least part by far is Medicare and Medicaid. "Put me in the hospital, Doc, for all these tests; my insurance (my Medicare) will cover it." "But, Sir," says the

harried physician, "you're not sick enough to lie abed at \$300 per day!"

It has not been assessed nor measured, we're sure, but it is likely that such hospitalizations for specious reasons, have already been curbed and kept from costing two to three times more than they now cost, by conscientious physicians who are as concerned over the health of their patients' pocketbooks as they are over the health of the patient. Physicians are only slightly less concerned with sparing the cash reserves of insurance carriers. Their patients, on the contrary, seem to show little concern. It will take the understanding and cooperation of the latter to produce any diminution of over-utilization whatever, before one will be able to see any reduction in costs of medical care.

"People pressures" is something every practicing physician has to learn to deal with, every hour of every day. He is pressured to prescribe pills, for example. The cost be damned! If a patient is told by his doctor that he is handling his own illness quite well, and that he does not need a "shot," nor a prescription for antibiotics for his cold, that patient, quite often, will tell the next physician he consults that the first physician

charged him and "did nothing for me!"

It is "people pressures" that makes hospitals compete with each other in the type of service offered, the latest equipment proximately available, and the greatest conveniences and amenities offered, from private room to color TV, etc.

So . . . how do we turn off the burner under the hospital cost pot?

We happen to think that it is the medical profession that needs to focus on the problem—not by second-guessing the attending physician as in utilization review, nor by participating in so-called "health planning" which is centered about Certificate of Need processing—but by scrutinizing in- and out-hospital care. We would urge both the A.M.A. on the national level, and the H.M.A. on the local level to review objectively our hospital system and how it could be fitted into a new approach to the care of the sick and the injured and the disabled.

We'll continue in the next issue of this Journal, but in the meanwhile, readers who are genuinely concerned might think on it and come up with suggestions and pet remedies.

J.I.F.R.

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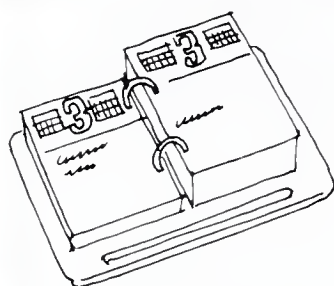
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LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

(Contact CME Dept. for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
 2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
- Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
- Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
- Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room

3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

St. Francis Hospital

1. Medical Grand Rounds, Tuesday (4th & 5th) 12:30-1:30 p.m. Sull. IV Classroom
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
7. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

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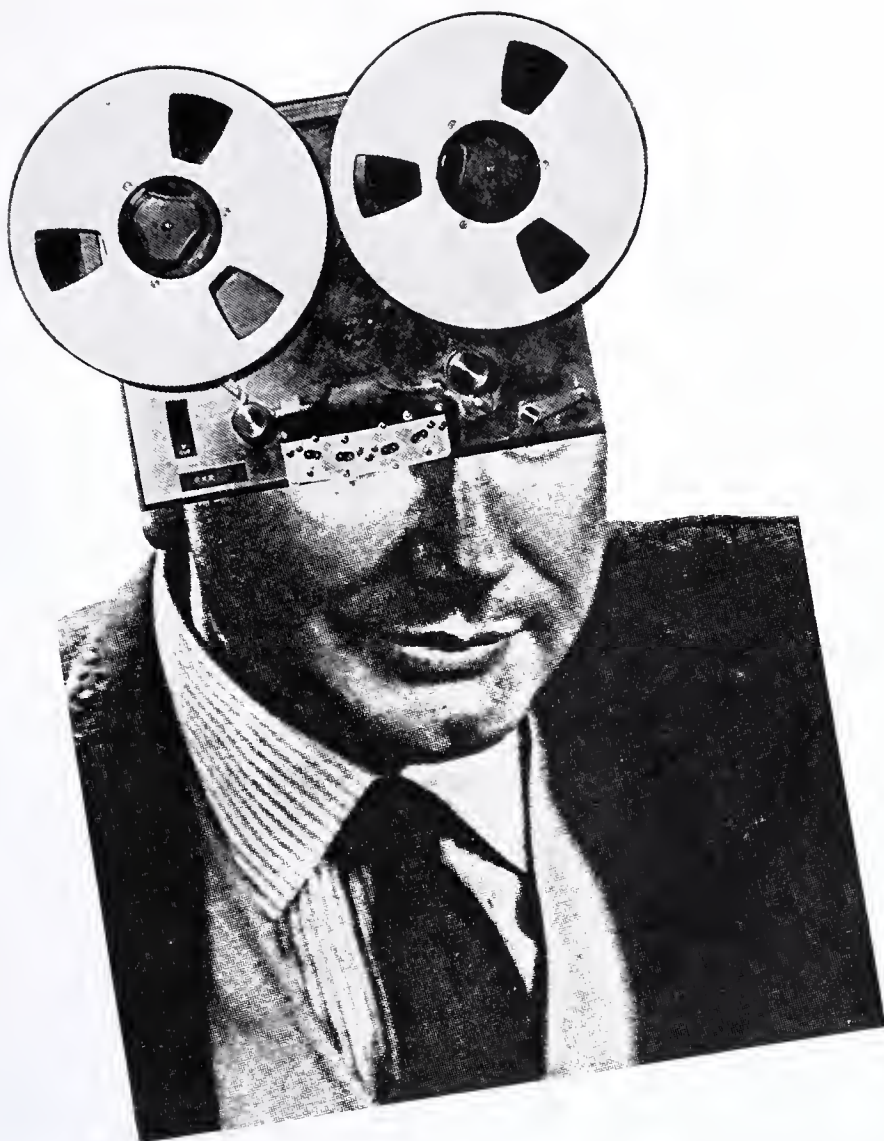
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8. Orthopedic Departmental Conf. 3rd Friday ea. month. 7:30-8:30 a.m. Med. Staff Board Rm.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Honolulu County Medical Society and Local Hospitals, Honolulu

Type: I, 1 hr/day, 1 day/mo from 12 mos

Fee: None Methods: AV, O, Pan

Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

Type: I, 1 hr/day, 1 day/mo for 8 mos

Fee: None Methods: AV, Clin C, O, Pan, R

Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

- Apr. 30, June 7, 1977 Management of the Surgical Patient. Stanford Univ. Schl. of Med. Stanford, CA 94305. Held at Mauna Kea Beach Htl. Kamuela 96743. 7 days 27 hrs. Fee \$275.
- May 31, July 8, 1977 Summer Institute in Gerontology-Univ. of HI -Schl. of Social Work; HI Hall. Cat. 1 CME. Contact: Jim Kelly, M.D., Dir. (808) 948-6623.
- June 4, 1977 Asthma-Planning For Diagnosis, Treatment and Patient Education-Sat. 7:30 a.m. Kaiser Pac. Aud.-Kaiser Hsp. 1 hr. Cat. 1. Speaker: Alexander Roth, M.D. Contact: CME Dept. Kaiser for further info.
- June 11, 1977 Ultra Sound-Sat. 7:30 a.m. Kaiser Pac. Aud.-Kaiser Hsp. Speakers: Drs. Peter Clapp & Gordon Ing. 1 hr. Cat. 1. Contact: Kaiser CME Dept. for further info.
- June 11-18, 1977 Orthopedic Review-Univ. of So. Cal. Schl. of Med. 2025 Zonal Ave., LA 90033. Held: Mauna Kea Beach Htl. Kamuela, HI. 5 days-30 hrs.
- June 13, 15, 1977 Pediatric Post-Graduate Infectious Disease Seminar. Univ. of HI-Dept. of Ped. Held at Shriner's Hsp. Speakers: Drs. Paul F. Wehrle & Margaret H.D. Smith. Fee \$50. Cat. 1 credit. Contact: Med. Ed. office-Children's Hsp. (808) 947-8511 for details re: registration.
- June 18, 1977 Venereal Disease Part 1-Venereal Infections Exclusive of Gonorrhea-Sat. 7:30 a.m. Kaiser Pac Aud.-Kaiser Hsp. Speaker: Richard Fardal, M.D. 1 hr. Cat. 1. Contact: Kaiser CME Dept. for further info.
- June 18-25, 1977 Lab Management for Pathologists-Univ. of So. Cal. Schl. of Med. 2025 Zonal Ave., LA 90033. Held: Mauna Kea Beach Htl. Kamuela, HI. 5 days-30 hrs.
- June 25, 1977 Amyloidosis-Sat. 7:30 a.m. Kaiser Pac. Aud.-Kaiser Hsp. Speaker: Vera Hlaing, M.D. 1 hr. Cat. 1. Contact: Kaiser CME Dept. for further info.
- June 25-26, 1977 Geriatric Workshop-Univ. of HI & Schl. of Med. Cat. 1-CME. Cost: \$100-practicing phys., \$50-retired phys. & no cost-students & residents. Contact: Jim Kelly, M.D., U of H (808) 948-6623.
- July 14-15, 1977 "Pesticide Protection for Health Personnel," Univ. of HI, Manoa campus. 8:30 a.m.-4:00 p.m. Held at Bi-Med Sci. Bldg. T 208. 10 hrs. Cat. 1. Fee \$50. Sponsored by: U.S. Environmental Protection Agency-U of Miami Schl of Med. For more info contact: Lyle Wong, HI Epidemiologic Studies Program, 737-8811.
- July 15-16, 1977 Conf. on Anaerobic Infections: Diagnosis & Management. held at Mabel Smyth Aud. 510 So. Beretania, Honolulu. 9 hrs. Cat. 1. Contact: Queen's Med. Cntr. CME Dept. for further info.
- Aug. 8-21, 1977 Visiting prof. of Oncology. Am. Cancer Soc. HI Div. 200 N. Vineyard Blvd. Honolulu 96817. 10 days, 40 hrs. no fee. Ph. (808) 531-1662 for further info.
- Aug. 1977 20th Annual Postgraduate Refresher Course. Univ. of So. Calif., Schl. of Med. 2025 Zonal Ave., LA 90033. Held at Honolulu, Maui, Kauai, Kona. 37 hrs. Phil R. Manning, M.D. Assoc. Dean.
- Oct. 31, Nov. 4, 1977 HMA Annual Mtg.-AMA Regional. Sheraton-Waikiki, Honolulu. Contact: Mrs. Bess Chang -HMA 320 Ward Ave. S 200, Honolulu 96814 or (808) 536-7702.



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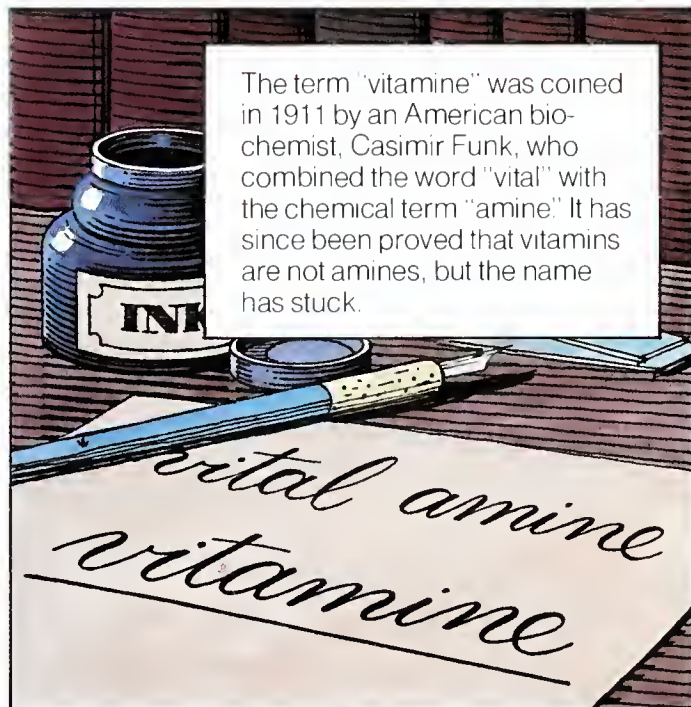
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Hawaii Academy of Family Physicians' Newsletter

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30 Years of Caring

Plan Now To Attend
the
AAFP's Annual Scientific Assembly
October 10-13, 1977
Las Vegas, Nevada

New Members—**Jacob W. Gerritsen MD** is a new Resident Affiliate member and **Curtis W.Q. Lee** is a new Student member at UH School of Medicine '79. Welcome!!

Dropped—Student **Kathleen Myers** and Student **Eliot Tomomitsu** for reasons unknown but technically for non-payment of dues. Sorry! **Doug Doyle** has resigned.

News of Members—**Kevin Kunz UHSM '78** is back from a sojourn in Washington D.C.; **Robert Kulani Childs MD**, ex-member, announced his wedding in the *Honolulu Advertiser* 18 April; **Verne Adams** of Pahala on the Big Island will have a new address: c/o Johnson Memorial Hospital, Smithfield, N.C. as of 1 June 77—we wish Verne well in his new location. **John Newman** of Lahaina, Maui, is available for *locum tenens* until he relocates somewhere. **Glen Stahl** has volunteered to be the physician serving the Kaneohe Child Health Conference; **Lincoln Luke** has been the CHC physician for the past 20 years. In view of the pittance paid by the State, such service is tantamount to charity.

CME—Unfortunately, news of the "Family Therapy Workshop" at TAMC on 9-12 May reached us too late to get in the previous issue of the HMJ; it sounded like a very interesting program taking up 3½ hours each weekday except Friday for a total of 12 hours; Category P status was not confirmed, however, by this printing. Advance notice of the Kona 1977 Invitational Scientific Congress 13 to 20 October, following the annual meeting in Las Vegas, states that Hawaii members AAFP may attend without paying any registration fee. AAFP wants immediate notice of intention to attend, however. This one is good for 16 p.

Home Deliveries—**Jim Langworthy** of Lanai was the instigator for the Hawaii Regional Perinatal Center to look at statistics:

	1974	1975	1976 thru Oct
Births not in hosp or institution	127	113	134
Of these, neonatal deaths	5	4	4
Mortality rate per 1000 live births	39.4	35.4	29.9
As compared, small hosp (100 births/yr)	19.9	14.6	11.3 (6 mos. all Hawaii)
As compared, medium hosp (100-500 births/yr)	13.6	6.0	11.3
As compared, Kapiolani (5000 births/yr)	12.5	9.6	9.5 (6 mos.)

Our comment: Does this include births in cars at hospital doorsteps or on the road?

We found a fee schedule for Maunaloa, Molokai of October 1948 when it was purely a Libby McNeil & Libby pineapple plantation village isolated from the rest of Molokai when the dirt road became too muddy for cars:

Pre-employ exam	\$ 3.00
Annual exam	depends
DPI—teacher exam	3.00
Premarital, each party	3.00
Adult circumcision	20.00

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Friday, April 1, 1977
5:30 p.m.

CALL TO ORDER

The meeting was called to order by President Calvin C.J. Sia. Also present were Drs. William Dang, Douglas Bell II, Grover Batten, Marion Hanlon, Herbert

Chinn, Ann Catts, William Kepler, Richard Lundborg, Albert Chun-Hoon, George Goto, J.I.F. Reppun, Leonard Howard, John W. Edwards, Calvin C.M. Kam, Arnold Siemsen, Sakae Uehara, Peter Kim, Roy Kuboyama, and Paul Condit plus Drs. Thomas Lau, Andrew Morgan, Reginald Ho, Thomas Cahill and Attorney V. Thomas Rice and Mrs. Thomas Cahill.

MINUTES

The minutes of the March 4, 1977 meeting were approved as circulated.

REPORT OF THE TREASURER

A. February financial statement: The February 1977 financial statement was reviewed in detail by the Treasurer. Dr. Batten noted that the Finance Committee will try to have an analysis of the first six months of operation of the 320 Ward Building available at the next Council meeting.

ACTION:

It was voted to approve the February 1977 statement subject to audit.

B. Recommendations of the Finance Committee: The Finance Committee reported that the AMA had contacted the executive director of HMA indicating that the proposed \$50 registration fee for non-HMA members at the annual meeting should be reconsidered in view of the fact that non-members will also be registering for postgraduate courses for which there are fees. As a compromise, it was agreed by the Finance Committee to recommend that the Council approve a \$25 registration fee for non-HMA members.

ACTION:

It was voted to approve the recommendation of the Finance Committee that the registration fee for non-HMA members at the 1977 annual meeting be \$25.

Dr. Batten reported that the Finance Committee had also considered two bills for payment: HMA attorneys had estimated the work for review and setup of the HMA pension plan would amount to between \$400-\$700. The work took a lot more time than anticipated and resulted in \$8,300 of time invested. In view of the original estimate, the attorneys agreed to accept whatever fee the Council deemed reasonable. The Finance Committee recommended that the original fee of \$700 be paid to the attorneys and that any subsequent work which might be necessary on the pension plan be paid at an hourly rate of \$55.

ACTION:

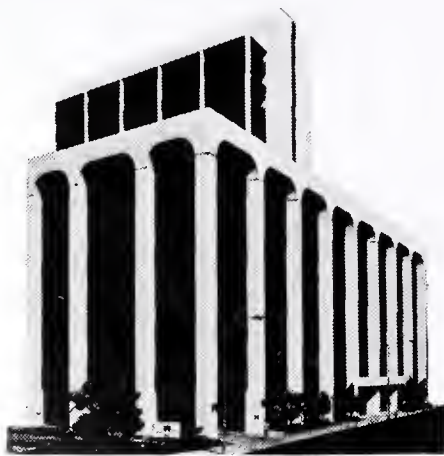
It was voted to accept the recommendation of the committee that \$700, the original fee, be paid to HMA attorneys for work done on the HMA pension plan and that any subsequent work done on the plan be paid at a rate of \$55 per hour.

The second bill covered fees for legal services for the HMA Suit on the question of the constitutionality of Act 219 in requiring physicians to carry insurance in order to be licensed. The Finance Committee recommended that the bill of \$28,711.01 be processed for payment.

ACTION:

It was voted to accept the recommendation of the Finance Committee to proceed with payment of the legal fees for the HMA Suit on Act 219 in the amount of \$28,711.01.

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REPORT OF THE SECRETARY

The secretary reported that as of the close of business on March 31, 1977, there were a total of 194 members who were delinquent in dues. It was also noted that a similar number had not forwarded payment for the Building Fund. There were some questions regarding the constitutionality of forcing members to contribute to the building fund. HMA Attorney Tom Rice reviewed the HMA Bylaws and noted that the provisions for the capital investment fund had been duly passed by the House of Delegates and Council and that it was constitutional to collect contributions to the building fund and to drop members for non-payment. It was noted that perhaps some communication to those delinquent outlining the meaning of HMA membership, the building fund, and the dollar value placed on certain membership benefits might be beneficial.

ACTION:

A motion to defer the grace period for delinquent members who had not paid dues or the 1976 building fund contribution be deferred until the next Council meeting. The motion failed to pass.

REPORTS FROM COMMITTEES AND COMMISSIONS

A. Cancer: Attorney Tom Rice was asked to comment on the question of whether the Executive Committee of the Cancer Center was truly executive in nature in view of his review of the CCH grant applications. He noted that the grant is somewhat like a charter and bylaws of an organization and in his opinion, the executive committee as outlined in the grants for the Cancer Center is truly executive in function. Dr. Sia noted that the Cancer Center originally evolved as an epidemiology/demography center and was fully supported by the HMA, Cancer Society and Hospital Association. The Executive Committee was appointed by the president of the University of Hawaii.

Over the years the director of the Center had bypassed the executive committee and there is some question at present regarding the role of the committee, whether it is truly executive in nature or not. At the 1976 House of Delegates meeting, the HMA Cancer Committee brought to light some of the problems that have arisen in connection with the Cancer Center. In trying to determine the contract relationship with the RCUH for operating the Hawaii Tumor Registry, it became apparent that the issue of whether the executive committee was executive or not was an important one. A meeting has been scheduled with the president

of the University to discuss this further. Dr. Reginald Ho, President of the Cancer Society, also confirmed that the ACS seeks to clarify the question regarding the executive committee as well.

Dr. Condit reported that the HMA Cancer Committee met on March 29 to discuss relations with the Cancer Center and to review the Cancer Center Core Support Grant. The Cancer Committee voted unanimously to accept the recommendations outlined by an ad hoc cancer subcommittee as follows: (1) That the HMA should withdraw from the Executive Committee of the Cancer Center of Hawaii, (2) Direct that communication with the Cancer Center of Hawaii should be through the president of the HMA, and (3) that the National Cancer Institute should be notified of this administrative adjustment. Copies of an internal memorandum outlining the background of HMA's relationship with the Cancer Center of Hawaii as well as three alternative actions for Council consideration were circulated. After considerable discussion regarding the recommendations, motions were made as follows:

ACTION:

It was moved and seconded that the Council adopt Alternative A of the Internal Report in lieu of the Cancer Committee recommendation number 1, and to adopt Recommendations 2 and 3 of the Cancer Committee.

It was moved to postpone action on the motion until after the meeting with the president of the University of Hawaii. (This motion was later withdrawn.)

It was moved to amend the original motion as follows: That the Council approve action on Alternative A and Recommendations 2 and 3 of the Cancer Committee and postpone the implementation of any actions until after the meeting with the president of the University. The motion was seconded and passed.

A motion to refer the question to the HMA Executive Committee for action failed to pass.

A motion to substitute Alternative B for Alternative A lost to a tie vote.

B. Self-Insurance, Ad Hoc committee: Dr. Edwards noted that a letter had been written to the actuary who had done some of the work for the Frank B. Hall report several years ago. The actuary noted that the study that was done was not really an actuarial study but was based on several hypotheses. He is no longer working in this field and would not be available to do further studies in Hawaii. Dr. Edwards also reported that the committee had met with Mr. Larry Baker, President of Argonaut Insurance Company, on

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March 31. Mr. Baker was very candid and reviewed the historical problems Argonaut faced over the past five years and gave some idea regarding the present situation. Argonaut will propose a 28% increase in premiums to the Hawaii Insurance Commissioner to become effective on June 1, 1977. He circulated several balance sheets to justify the increase and noted that Argonaut had not been granted the full increase they sought last time and therefore, as had been predicted, would need to increase rates to keep up with the number of cases filed and the increase in the amount of awards. Dr. Edwards also reported on a meeting held with a representative from Professional Economic Services, Inc. (New York) which has been involved in providing insurance for the American College of Emergency Physicians. Their plan features a trust fund which is controlled by physicians in which a specified amount of premiums is set aside for a given period of time. It is expected that much of the trust fund could be returned to physicians if experience is good. This concept is rather unique and will be explored further. It was also reported that the enabling legislation for physician's cooperatives had passed the Legislature. It was suggested that the HMA leadership express the concern of the Council regarding the proposed Argonaut rate increase to the Insurance Commissioner, noting that the increase does not appear to be representative of actual losses.

C. Legislation: A legislative summary outlining the status of certain health-related measures was circulated to the Council. A copy of Senate Bill 1059, H.D.1, which contains amendments to act 219 (medical malpractice insurance law) was also circulated. This version of the bill is expected to pass final reading in the Legislature. Its primary feature is to delete the mandatory requirement of insurance for licensure as well as mandatory participation in the Patient's Compensation Fund. A proposed resolution regarding the hire of a physician during the legislative session was postponed.

D. Public Affairs: The TV-Radio Committee requested Council approval to proceed with the purchase of video tapes which can be used to tape interviews with physicians which can be circulated to all closed circuit TV stations. Funds are included in the budget approved by the House of Delegates.

ACTION:

It was voted to proceed with the purchase of the video tapes.

E. Commission on Health Services: The Community Health Care Committee, a joint committee of the HMA and Honolulu County Medical Society, recommends to the HMA Council that they support the proposal of the Convalescent Center of Honolulu for a certificate of need for an increase of skilled nursing beds and that a letter of support be written to CHP.

ACTION:

In view of the fact that the request for support is for an institution in Honolulu County, the recommendation was referred to the Honolulu County Medical Society Board of Governors.

OLD BUSINESS

A. Election of Members to the HFMC: The Board of Directors of the Hawaii Foundation for Medical Care proposed the following nominations for election to the HFMC Board of Directors: Richard Lundborg, Verne Adams, Robert Simmons, and Thomas Cahill.

ACTION:

Drs. Lundborg, Simmons and Cahill were elected to the HFMC Board of Directors.

NEW BUSINESS

A. HAMPAC: Dr. Howard reported that as of March 21, 1977 there were 285 members of HAMPAC and 10 sustaining members. He also noted that expenses for the HAMPAC/AMPAC Workshop had been considerably higher than anticipated due to poor attendance figures and requested a supplemental budgt for HAMPAC's educational fund.

ACTION:

It was voted to approve \$250 for the HAMPAC Educational Fund.

B. New ad hoc committee: Dr. Sia reported that Dr. Reppun had agreed to chair an ad hoc committee which will look into discriminatory practices of insurance carriers. The committee met and will begin to collect some data.

C. Humanities Seminar for Medical Practitioners in 1977: Dr. Sia announced that there are some scholarships available for a one-month seminar for medical practitioners. Brochures are available in the HMA Office.

D. Reports from County Societies: The county medical society presidents reported on activities in their respective counties. Dr. Kim noted that new officers had been elected in Kauai as follows: Thatcher

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Magoun, President; Rex Couch, Vice-President, and Yonemichi Miyashiro, Secretary-Treasurer. Dr. Robert Hamblin will serve as Delegate to the HMA with Alternate Delegate Dr. W.W. Greene.

ADJOURNMENT

The meeting adjourned at 9:00 p.m.

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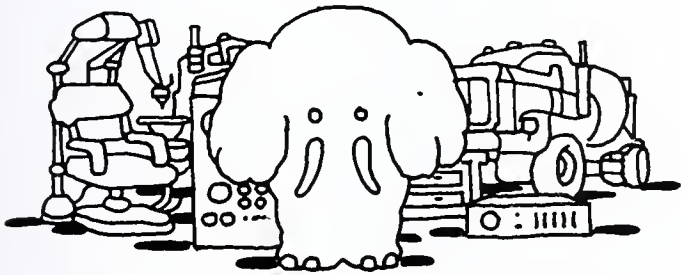
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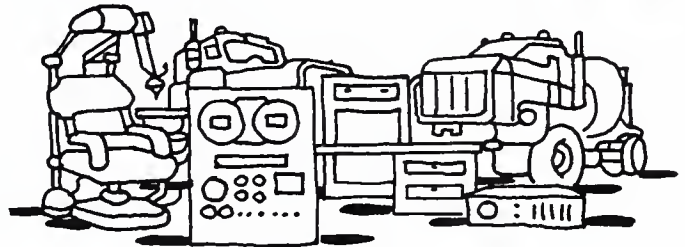
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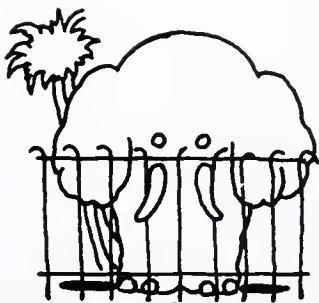
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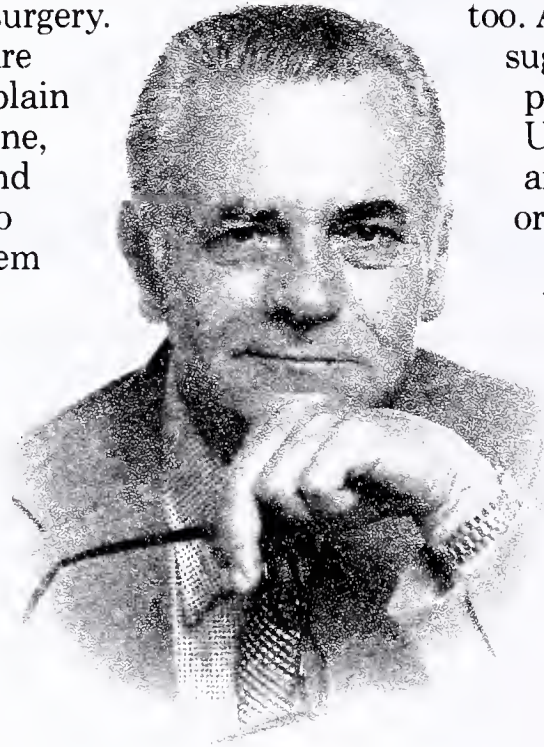
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JUNE 1977
VOL. 36, NO. 6

Hawaii Medical Journal

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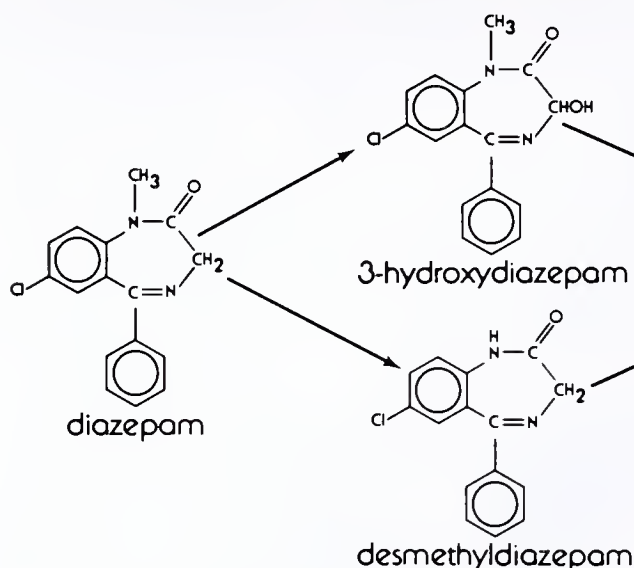
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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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31

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tablish safety in early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy.

Precautions: Because of the ephedrine component this drug should be used with caution in elderly males or those with known prostatic hypertrophy.

The potentiating action of hydroxyzine, although mild, must be taken into consideration when the drug is used in conjunction with central nervous system depressants; and when other central nervous system depressants are administered concomitantly with hydroxyzine their dosage should be reduced.

Patients should be warned—because of the hydroxyzine component—of the possibility of drowsiness occurring and cautioned against driving a car or operating dangerous machinery while taking this drug.

Adverse Reactions: With large doses of ephedrine, excitation, tremulousness, insomnia, nervousness,

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A child is lying in bed, covered by a quilt with a vibrant, multi-colored pattern of squares and rectangles in shades of blue, green, orange, and purple. The child's head is visible at the top left, and their legs are visible at the bottom right. The background is a plain, light-colored wall.

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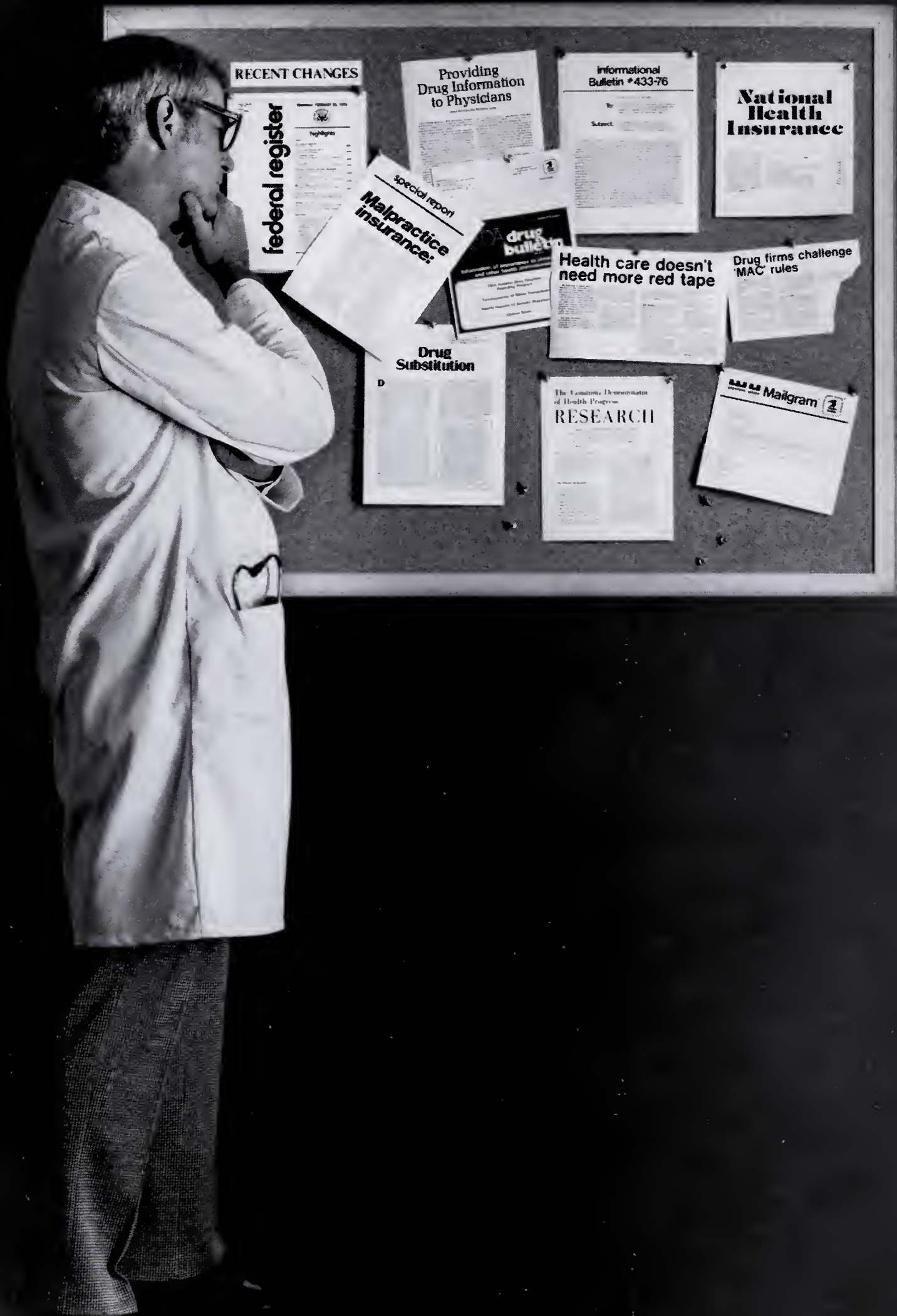
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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

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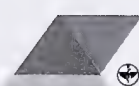
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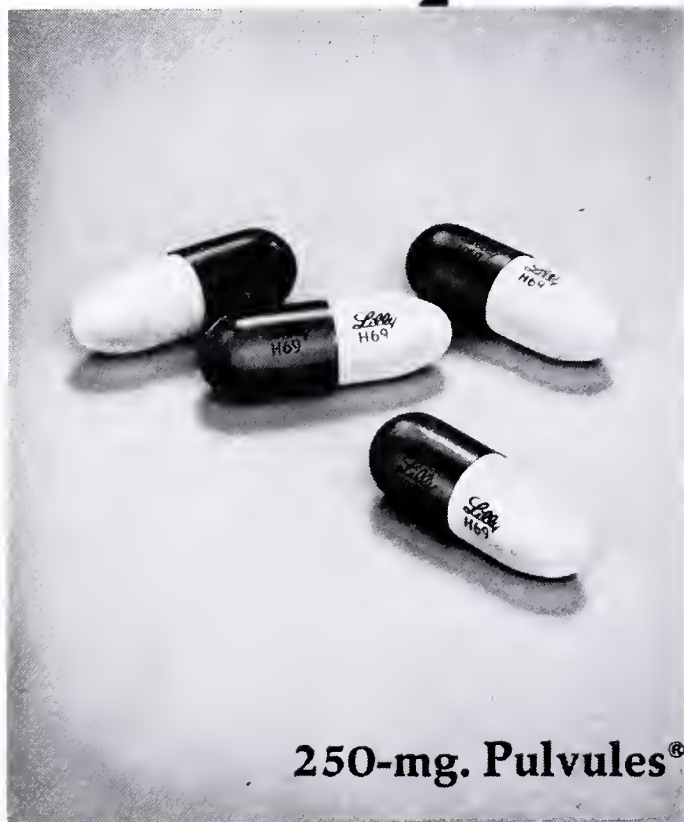
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Chronic Lymphocytic Leukemia in Japanese in Hawaii

FORTUNATO V. ELIZAGA, M.D.* and NOBORU OISHI, M.D.** , Honolulu

● *Histories of nine patients with the diagnosis of chronic lymphocytic leukemia (CLL) during the 12-year period, 1960-1972, were reviewed. Six patients showed the clinical and morphologic findings consistent with CLL. It comprised 4.2% (6 out of 141) of all cases of leukemia among Japanese. Survival appeared to be influenced by the age of the patient and the initial peripheral leukocyte count. Shorter survival (less than 2 years) was noted in patients over 65 years and with initial peripheral leukocyte of more than 50,000/mm³. There was 2:1 female-to-male ratio. CLL was confused with lymphosarcoma in 2 cases. CLL among the Japanese in Hawaii is rare, as it is in Japan, possibly related to genetic factors.*

Chronic lymphocytic leukemia (CLL) is the most common type of leukemia in the western world, and more often occurs in men than in women.¹ It is a generalized, progressive, and self-perpetuating lymphoproliferative disorder, particularly affecting the small lymphocytes.² It was originally described by Dameshek as an accumulative disease of immunologically incompetent lymphocytes.³ Recently it has been shown that it is a disorder of B lymphocytes.⁴ Adenopathy, splenomegaly, lymphocytosis in the peripheral blood and the bone marrow, and decrease in the circulating immunoglobulins are the clinical manifestations.

CLL is a rare disease among Japanese and Chinese.⁵⁻⁹ Studies in Japan showed an incidence of 2-3% of all leukemias.^{5,6,8} Jim, during 10-years in private practice in Hawaii, saw only one Japanese with CLL, a rate of 0.4 per 100,000 patients, compared to 1.9 among whites.¹⁰ It has been calculated that the incidence of CLL in the United States is 20 times that in Japan.⁷

The rarity of CLL in Japan prompted us to review all the cases of CLL in Japanese in the State of Hawaii reported during a 12-year period.

Materials and Methods

Nine case histories of patients of Japanese ancestry with the diagnosis of CLL during a 12-year period from 1960-1972 were located in the Hawaii Tumor Registry (Table 1). Medical records and available histologic materials were reviewed. Clinical and hematologic data on the patients were summarized and tabulated. Six bone marrows were available for review.

The diagnosis of CLL was established on the basis of the characteristic histologic features, which have been well described.¹ Physical findings varied according to the stage of the disease. Adenopathy and splenomegaly were thought to be significant after other possible causes had been ruled out. Absolute lymphocytosis in the peripheral blood and marrow infiltration with the same lymphocytes were noted.

Results

The diagnosis of CLL was confirmed in only 3 patients with available bone marrow tissues. Bone marrows were lost for 2 patients (patients 3 and 4) with clinical and laboratory features of CLL, and the other patient (patient 5) had no bone marrow for review. On patient (patient 9) had persistent monoclonal gammopathy, IgG, with lytic lesions in the skull. The bone marrow showed 69% lymphocytes and few plasma cells. The bone marrows of 2 patients (patients 7 and 8) showed large lymphocytes with cleft or indented nuclei characteristically seen in lymphosarcoma.

The total number of patients of Japanese ancestry with leukemia in the Hawaii Tumor Registry from 1960-1972 was 144. The 9 cases diagnosed CLL represented 6.2% of the total (Table 2). Our revised figure after review was 4.2% (Table 3).

All but one of the patients were over 50 years old at the time of diagnosis. Median age was 66 years. Of the 4 women and 2 men, four had been born in Japan and 2 in Hawaii. More than half had adenopathy and 1/3 had splenomegaly. The

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TABLE 1.—Chronic Lymphocytic Leukemia in Japanese in Hawaii, 1960-1972.

CLINICAL AND HEMATOLOGIC FINDINGS AT TIME OF DIAGNOSIS

Pa- tient	Age in yr.	Sex	Birth- place	Year of dx	Adeno- pathy	Spleno- megaly	Hepato- megaly	WBC x1000 /mm ³	% lymphs P. Blood	HgB g/dl	Plate- lets /mm ³	% lymphs marrow	Sur- vival in mo.	Remarks
1	64	F	Japan	1969	+	0	0	16.9	77	13	adeq.	70	60	Lost to follow-up Oct. '74
2	77	M	Japan	1967	+	0	0	46.0	79	10	adeq.	65	27	Died of pneumonia
3	54	F	Hawaii	1968	+	+	0	18.5	57	14	224	unavail- able	87	Died of pneumonia
4	42	F	Hawaii	1963	+	+	0	22.0	74	14	276	unavail- able	72	Died of GI bleeding
5	89	M	Japan	1963	0	0	0	38.0	75	9.7	172	unavail- able	0.25	Died of sepsis?
6	75	F	Japan	1970	0	0	+	77.0	90	12	50	80	17	Died of pneumonia
7	77	M	Japan	1961	0	0	+	40.9	64	13	adeq.	50	0.3	Lympho- sarcoma. Died of pneumonia.
8	64	M	Japan	1966	+	0	+	53.0	94	12	150	62	?	Lost to follow-up. Lympho- sarcoma.
9	78	M	Hawaii	1968	0	+	0	9.1	43	13	adeq.	69	72	Monoclonal gammopathy. Lytic lesions in skull. Died of sepsis.

TABLE 2.—Cancer of Lymphatic and Hematopoietic Tissues in Hawaii Residents, 1960-1972.*

TYPE	JAPANESE		CHINESE		OTHERS+	
	NO.	%	NO.	%	NO.	%
Chronic lymphocytic leukemia	9	6.2	3	7.6	41	12
All Leukemias	144	100	39	100	335	100
Reticulum cell sarcoma	45	20	8	18	75	12
Lymphosarcoma	57	26	14	31	111	21
Hodgkin's Disease	47	21	9	20	136	26
Other Lymphoma	68	31	13	29	201	38
All Lymphomas	217	100	44	100	523	100

*Source: Hawaii State Tumor Registry.

+Whites and other orientals.

TABLE 3.—Chronic Lymphocytic Leukemia and other Types of Leukemia in Japanese and other Racial Populations in Hawaii, 1960-1972.
(Revised figures after review)

TYPE OF LEUKEMIA	JAPANESE		ALL OTHER RACES*	
	NO.	%	NO.	%
Chronic lymphocytic	6	4.2	44	11.7
Others	135	95.8	330	88.3
Total	141	100.0	374	100.0

*Include Chinese and other orientals.

initial peripheral leukocytes in all but 2 patients exceeded 20,000/mm³, there being absolute lymphocytosis of the small lymphocytes. Bone marrows showed characteristic, widespread lymphocytic infiltration. Three patients survived more than 5 years after diagnosis and the other 3 lived less than 2 years, only 7 days in one case.

The long survivors (more than 5 years) were less than 65 years old and the short survivors (less than 2 years) were over 65. The long survivors had fewer initial peripheral leukocytes (average 15,000/mm³) than the short survivors (average 50,800/mm³). The median survival was 43.8 months. Most died of complicating infections.

Discussion

The present review is consistent with previous studies in Japan and United States indicating the rarity of CLL among Japanese. The reasons for this rarity are still not known. Genetic factors probably play a role in the etiology of CLL.¹¹ Other factors like chemical carcinogens and oncogenic viruses have not been found to be related to this disorder.¹² The association with previous exposure to ionizing radiation in acute leukemia and chronic granulocytic leukemia is well known.¹⁵⁻¹⁷ The study by Finch *et al* in Nagasaki and Hiroshima showed negative relationship between CLL and ionizing radiation.⁵

Western influence was considered as a possible factor in the higher incidence of CLL in Kawakita, a city closer to Nagasaki, than in Kumamoto.⁵ Our data is not consistent with their finding. Japanese in Hawaii have been westernized for more than half a century. Nevertheless, the rate of CLL among the Japanese in Hawaii is strikingly low. It has been suggested that a study of CLL in Japanese residents of other countries will help elucidate this phenomenon. As far as we know there is no world-wide epidemiologic study of CLL in Japanese outside of Japan to date. In 1970 the population of Hawaii was 777,000, more than 1/3 being of Japanese ancestry. This makes Hawaii an ideal area for epidemiologic study of CLL among Japanese outside of Japan.

Like Finch *et al*, we observed an overdiagnosis of CLL. Of 9 patients listed at the Hawaii Tumor Registry, only 3 conclusively had the disease and 3 other patients probably had it, judging by peripheral blood smear only. Two patients had lymphosarcoma, which is frequently confused with CLL. The occurrence of lymphosarcoma among Japanese in Hawaii is 26% of all lymphomas (Table 2), comparable to the figures noted in Japan which are 20-30%.¹⁶⁻¹⁸ Although the clinical and histologic features of CLL are quite characteristic, difficulty in diagnosis is frequently encountered.

The median survival of patients with CLL is 5 years under good conditions; 1/3 live for more than 10 years.¹ Significantly shorter survival was noted among Japanese than whites. Seven of the 13 patients died within 1 year from the time of the diagnosis.⁵ In our study, the median survival was 3 1/2 years, with a range of 0.25 to 87 months. The majority died of infection which is a major cause of death in leukemic patients. The age of the patients at the time of the diagnosis appears to influence survival. Our long survivors were all less than 65 years at the time of diagnosis. Why the short survival among the Japanese with CLL is not known. Genetic factors might be involved.

CLL occurs more often in men than in women with a male-to-female ratio of more than 2:1.¹ Separate studies by Tomonaga and Shimkin *et al* among the Japanese in Japan and the United States respectively revealed the same ratio.^{7,6} However, the study by Finch *et al* and this present study are not consistent with their observations.⁵ Finch *et al* found CLL in 8 women and 5 men, and we found it in 4 women and 2 men. This inconsistency could be related to the small number of cases.

CLL is a disorder of B lymphocytes and, therefore, impaired humoral immunity is characteristic.⁴ Recently Yodoi *et al* reported 2 cases of CLL of the T cell type in Japanese.¹⁹ Is the type of lymphocytes involved in CLL related to survival? We are unaware of any report relating survival to the type of CLL. Study of this aspect might help to determine the reasons for the short survival among the Japanese.

Acknowledgment

We are grateful for the help and cooperation we received from the Hawaii Tumor Registry, particularly from Drs. Thomas A. Burch and Will Rellahan, and from staff at Castle Memorial Hospital, Kuakini Medical Center, Maui Memorial Hospital, The Queen's Medical Center, Saint Francis Hospital, and the Hawaii State Hospital.

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The Incidence of Intestinal Parasites in Some Hilo Hospital Patients*

NALEEN ANDRADE, B.A. and KAORU NODA, Ph.D., *Hilo*

The introduction of intestinal parasites to Hawaii by recent immigrants from Samoa, the Philippines, and Southeast Asia has alarmed some parasitologists in Hawaii.^{1 2} Our study, then in progress at the time of the above news releases, was to determine the kinds of human intestinal parasites and the incidence of infection in a selected population in Hilo.

Hawaii is indeed not isolated from the parasite problem. Previous reports^{3,4,5} show that amoebae, flagellates, trichurids, ascarids, hookworms, pinworms, and tapeworms are present in Hawaii.

Materials and Methods

Stool specimens were collected from 200 patients at Hilo Hospital during a 19-month period, October 20, 1974 to April 8, 1976. Each specimen was examined grossly for stool consistency and presence of worms, and direct smears were prepared. Zinc sulfate⁶ and formalin-ether concentration⁷ methods; and Wheatley's trichrome stain for suspected amoebae were made.

Data on ethnic background, age, and sex were recorded when available. A summary of the results is given in Table 1.

Results and Discussion

The occurrence of helminths and protozoans in the 200 persons examined is 11%. Power's survey of 1,009 persons in Maui's Hamakuapoko Camp showed a 32.9% rate of infection.⁴ Ching⁸ reported on 1,380 persons, including 185 from Hilo, with a 12% rate of parasitic infestation.

In our study, two parasites, the blood fluke, *S. japonicum*, and the echinostome, *E. ilocanum*,

TABLE 1.—*Helminths and Protozoans Observed in Stool Samples*

HELMINTH OR PROTOZOAN	NUMBER OF INFECTIONS	PERCENT INCIDENCE
<i>Schistosoma japonicum</i>	1	0.5
<i>Euparyphium ilocanum</i>	1	0.5
<i>Hymenolepis nana</i>	2	1.0
<i>Taenia saginata</i>	2	1.0
<i>Trichostrongylus</i> sp.	1	0.5
Hookworm	3	1.5
<i>Ascaris lumbricoides</i>	8	4.0
<i>Trichuris trichiura</i>	4	2.0
<i>Enterobius vermicularis</i>	2	1.0
<i>Entameba histolytica</i>	2	1.0
Total Infections:	26	
Multiple Infections:	4	
Individuals Infected:	22 or 11.0%	

were recovered from an 85-year old man who was a recent immigrant from the Philippines. It is believed that he encountered these parasites in the Philippines where both are endemic. Since snails of the genus *Oncomelania* and *Pila*, which are intermediate hosts of *S. japonicum* and *E. ilocanum*, respectively, are not found in Hawaii, there is no danger of spread here.

Ascaris lumbricoides was the most common intestinal parasite occurring in 4% of specimens. Of the 8 infestations, 5 were found in whites, 2 having just returned from out-of-state trips.

A summary indicating the ethnic background and percent infection is given in Table 2.

TABLE 2.—*Incidence of Parasite Infection and Ethnic Backgrounds*

ETHNIC BACKGROUND	NUMBER EXAMINED	NUMBER INFECTED	PERCENT INFECTED
Hawaiian or Part-Hawaiian	28	1	3.6
Filipino or Part-Filipino	32	4	12.5
Caucasian	65	10	15.4
Japanese	26	1	3.9
Chinese	1	0	0.0
Others	3	1	3.3
Unidentified	45	5	13.3

University of Hawaii at Hilo
Hilo, Hawaii 96720

*This study was supported by an N.I.H. Minority Schools Biomedical Support Grant No. RR-08073.

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The beef tapeworm, *Taenia saginata*, was found in a middle-aged Filipino woman and in an unidentified person. The woman could have been infected by ingesting the cysticerci in pickled beef, *kilawin*, a dish commonly eaten by some Filipinos (Ilocanos). After a week of treatment with antihelminthics, the scolex was recovered from the patient.

The dwarf tapeworm, *Hymenolepis nana*, was found in a 44-year old Japanese and in an unidentified person.

Whipworms, *Trichuris trichiura*, were most commonly found in multiple infestations. A stool specimen from one 40-year old immigrant man from the Philippines contained ova of *T. trichiura*, hookworm, and ascarids. Another Filipino immigrant was infested with whipworm and hookworm. A whipworm ascarid infestation was noted in a Samoan immigrant. All 3 persons were most likely infected in their homelands.

The pinworm cases reported in this study are not indicative of the pinworm incidence in Hilo, since the anal swab technique or other specific tests were not employed.

Infections with *Entameba histolytica* were found in 2 white men, one of whom was a member of a commune in a rural area of the Big Island, where

he probably became infected.

The Hawaiian and Japanese ethnic groups had the lowest rate of infestation, 3.6% and 3.9%, respectively, in this study. One pinworm infestation was found among the Hawaiian group, one *H. nana* infection in a Japanese. No heterophyids were found in either of these ethnic groups which are generally consumers of *sashimi*, or raw fish.

Among whites, there was a 15% rate of infestation. *Ascaris*, 5; *Trichostrongylus* sp. 1; hookworm, 1; *E. histolytica*, 2; and pinworm, 1, were identified.

This study shows the presence of 10 parasites in 200 stool samples. Of these only two, *S. japonicum* and *E. ilocanum*, cannot propagate in Hawaii.

Acknowledgments

The authors are grateful to Mrs. Margaret Hirano, Hilo Hospital Medical Technologist, for her helpful advice and assistance; to Donna Lim, Biomedical student, for her assistance and Dr. Ayda Singh for his comments in the preparation of this manuscript. Special thanks go to the 200 Hilo Hospital patients who made this study possible.

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Case report

Development of Chronic Granulocytic Leukemia in a Patient Treated with Pyrimethamine

ROBERT T. S. JIM, M.D., F.A.C.P.,* and FORTUNATO V. ELIZAGA, M.D.,** Honolulu

● A 51-year-old Filipino housewife was treated with pyrimethamine for toxoplasmosis and two years later developed chronic granulocytic leukemia. A possible oncogenic effect of pyrimethamine is postulated.

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 **Clerical Instructor, University of Hawaii School of Medicine.
 Accepted for publication July, 1976.

Certain drugs, notably immunosuppressive and alkylating agents and diphenylhydantoin, are believed to be possibly oncogenic, inciting acute leukemias and lymphomas. Sadoff has reported on the development of reticulum cell sarcoma in a 56-year-old patient after 14 months of pyrimethamine treatment for toxoplasmosis. We

continued page 176

Estate Tax Relief's here:

How to make your money make it to your heirs.

No, we don't make your fortune for you.
But we might just be the one to save it.



By William E. Aull
Executive Vice President

Right now there are two important things you should know. One: The new tax law that's now in effect will reduce (or even eliminate) Federal Estate Taxes for many families.

Two: Your worth.

Put the two together and you could come up with a combination that will leave your family better off than you ever imagined. Especially if you're worth more than you think. (And that's not an absurd thought at all.)

So sit back and take stock.

You've got a home, maybe a condo on Maui, life insurance, securities, maybe some profit sharing or other fringe benefits. Or how

about artifacts and things that really count: jewelry, art objects, how about a boat?

Then there's your business.

All these holdings could put you in the \$300,000 bracket.

That's where Hawaiian Trust comes in. You see, we don't pretend to be able to make your fortune for you.

But we can manage what you've got.

We see your estate as one lump sum, all-encompassing.

In other words, we make it a full time job to keep you and your wealth unencumbered. Fully aware of the ins and outs of the new tax labyrinth, we make long range plans that make long range savings. Hawaiian Trust knows how and when to change your plan for maximum advantage to you and your heirs.

We know how to let you retire without a load of worries.

We know who you can give gifts to — and come out ahead.

For example, here is a look at the way combined estate taxes for husband and wife save what is tantamount to a fortune:

COMBINED ESTATE TAXES FOR HUSBAND AND WIFE

Value of Estate	If husband's will leaves wife owning everything outright	If husband leaves two- trust will	TAX SAVED with proper trust plan
\$ 500,000	\$113,609	\$ 42,800	\$ 70,809
600,000	156,724	74,400	82,324
800,000	243,104	136,000	107,104
1,000,000	331,401	197,600	133,801
1,500,000	559,091	361,800	197,291

These tax estimates assume that the wife survives the husband by ten years or more, and that both their taxes are reduced by the maximum \$47,000 tax credit. If the husband dies before 1981, the tax totals would be somewhat larger but the tax savings would remain substantial.

The column at the far right shows what happens when a proper trust plan is put into effect.

And that's just one example.

It keeps getting trickier and trickier, too; look at some of the titles under which new tax law changes have been made:

- Expenses—double deduction
- Generation-skipping trusts
- Gift tax "Gross-up"
- Gifts in contemplation of death.
- Marital Deduction
- Orphans' exclusions
- Sales of Inherited Assets

Plus plenty more. Equally esoteric.

Now if you've read this far you've got to be concerned about your future. So Hawaiian

Trust respectfully requests that you re-evaluate your assets, your will, your long-range portfolio. Then see a money-manager who is as good at his job as you are at yours.

That could be us.

Hawaiian Trust is a trust company and a trust company only. We currently manage over \$1.2 billion in personal and corporate investments.

See if you're the Picture of Wealth

Just run down the list here and see what a great-looking profile you've probably got. Bet you're wealthier than you thought.

Way to find out: give yourself one point for every \$1000 you enter in each category.

Equity in your home:	Pts. _____
Life insurance (face value)	Pts. _____
Cash (checking, savings, etc.)	Pts. _____
Profit sharing, Pension HR-10	Pts. _____
Stocks & Bonds	Pts. _____
Real estate	Pts. _____
Money due you (notes)	Pts. _____
Deferred compensation, etc.	Pts. _____
Sole proprietorship or partnership interest	Pts. _____
Misc. property (cars, furniture, jewelry, etc.)	Pts. _____

YOUR TOTAL _____

How did you do? If you came out with 300 points or more, you'd best give us a call. The number is 525-6567. Or return this coupon for further information.

Name _____

Address _____

Mail to: William E. Aull
Executive Vice President
Hawaiian Trust Company, Ltd.
Financial Plaza of the Pacific
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Honolulu, Hawaii 96802

(clip here)

Hawaiian Trust Company, Ltd.

Honolulu — Wailuku, Maui — Hilo

encountered a woman, treated with pyrimethamine for toxoplasmosis, who later developed chronic granulocytic leukemia.

Report of a Case

A 51-year-old Filipino housewife suddenly developed blurring of vision in her left eye in September, 1975. An ophthalmologist noted a massive posterior uveitis. Her peripheral blood showed leucocytosis ($79,000/\text{mm}^3$) and thrombocytosis ($800,000/\text{mm}^3$).

In July, 1973, she had noted blurring of vision in the same eye. An ophthalmologist had made a diagnosis of uveitis and chorioretinitis secondary to toxoplasmosis. No hepatosplenomegaly or lymphadenopathy were noted. Her peripheral blood showed hemoglobin of 12.5 g/dl, leucocyte count $9600/\text{mm}^3$ with normal differential, platelet count $336,000/\text{mm}^3$ and reticulocytes 1%. The initial toxoplasma titer was 1:250, and was 1:1024 2 months later. She received pyrimethamine 50 mg daily, sulfisoxazole 4 g daily and prednisone 40 mg every other day for 4 weeks. She had a complete resolution of the blurring of vision. Except for a slight decrease of her leucocytes to $4400/\text{mm}^3$, her peripheral blood remained normal. She had had tonsillectomy in 1961. She denied exposure to radiation or other drugs or chemicals. Her husband had been treated for pulmonary tuberculosis in 1963.

Physical examination revealed a slightly obese middleaged woman. The left eye showed a hazy vitreous and an area of fluffy white inflammation in the nasal portion of the choroid. There was anterior chamber reaction, with cells and flare. The spleen was not palpable. The remainder of the examination was normal.

Laboratory tests showed hemoglobin of 12.7 g/dl; leucocytes, $78,000/\text{mm}^3$, with the following differential: segmenters 28%, bands 42%, lymphocytes 8%, monocytes 2%, eosinophils 1%, basophils 5%, myelocytes 1% and metamyelocytes 13%; platelets, $860,000/\text{mm}^3$; reticulocyte count, 1.4%; and leucocyte alkaline phosphatase, 15 (normal, 15-70). The bone marrow was as markedly hypercellular with normal number of megakaryocytes. There was marked myeloid hyperplasia with slight increase in the number of eosinophils and basophils. The erythroid series was active with normoblastic maturation. The myeloid-to-erythroid ratio was 6:1 and stainable iron was absent. Karyotyping showed the Philadelphia chromosome. The toxoplasma titer was 1:256 and 1:512 four weeks later. The spleen was slightly enlarged on scan.

Comment

Sadoff's report of reticulum cell sarcoma developing after treatment with pyrimethamine raises the possibility of oncogenic effect of this drug.

To our knowledge chronic granulocytic leukemia developing after the use of pyrimethamine has not been reported. This patient had also received sulfisoxazole and prednisone. However, the development of leukemia following the use of these drugs has not been recorded. Whether any interaction between these drugs resulted in or potentiated some oncogenic effect is not known. Evidence strongly suggests that some drugs may have oncogenic activity. However, what genetic, environmental or other factors might be involved in oncogenesis is not known.

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BLEMISHES?

COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

Lydia O'Leary
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ALA MOANA CENTER—STREET LEVEL

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JON WON

Hawaiian Open Golf Tournament for 1978 needs physicians to tend to the needs, should they arise, of both players and spectators. From Wednesday, Feb. 1 through Sunday, Feb. 5, 1978, Waialae Country Club. Approximately 5 physicians needed, either half day or whole day: Feb. 1, 7:30 a.m.-5:00 p.m. (pro-am); Feb. 2 and 3, 7:30 a.m.-4:30 p.m.; Feb. 4 and 5, 7:30 a.m.-2:30 p.m. Red Cross, emergency vehicles, some equipment available. Physicians serving at least whole day or two half days will get two free passes and a shirt. Interested physicians call HMA office for contact.

Primary Care Center now recruiting for two physicians: Medical Director and Primary Care Practitioner. Board certified/eligible internists or family physicians. Outstanding opportunity to provide innovative health services with emphasis on preventive care. Interested physicians send curriculum vitae to Director of Primary Care, St. Francis Hospital, 2230 Liliha St., Honolulu, Hawaii 96819.

Kudos To Livingston Wong, M.D., who will "retire" as the Project Director of the HMA-EMS Program on July 1, 1977. After five years of developing and implementing this nationally-recognized program, he has decided that there are other things in medicine that he would like to devote time to. William Dang, M.D., will become the new Project Director on July 1st.

Council On Legislation of the AMA reports that HEW Secretary Califano, testifying before the Subcommittee on Health of the Senate Finance Committee, stated that physicians fees, like hospital costs, eventually may need cost controls. Secretary Califano has promised that he would send a specific recommendation to the Congress on the matter of physicians fees. (Physicians, watch out for that train!).

Certificate of Need Legislation has been enacted in West Virginia, making it the 34th state to do so (Hawaii is one of them). West Virginia's legislation specifically excludes physician's offices from Certificate of Need approval; Hawaii's law specifically *may* include physician's offices.

President of the Hawaii Medical Library, Dr. John Watson (who will be giving up his office to do medical missionary work in Pakistan) writes to HMA and the physicians to thank them for their support of the Medical Library. The increased funding by the HMA and the individual physicians has provided additional funds that will allow the Medical Library at least a bare bones existence through the end of fiscal 1978, but that the continued operation of the Medical Library after that date will depend on development of a viable approach to financing the library. An interesting note is that an independent management analysis of the operation of library services showed that about 30% of the usage was by people who are not financial supporters of the library.

Tel-Med Promotion is Needed to assure its success, and HMA, as a co-sponsor, needs to do its part. HMSA, the other co-sponsor, has conducted several promotional activities, such as periodic mailouts to health, community, and social organizations, posters on The Bus, and contacts with employer groups and HMSA members. Public service announcements are continually aired on radio and television. Tel-Med is a health information program provided through the cooperation of HMA and HMSA. It can be a valuable addition to physicians' health education efforts, and it needs individual physician support and active promotion by physicians to ensure its success. Promotional material for physicians offices are available at the HMA office.

The Governor of Hawaii, George Ariyoshi, signed into Law SB 1059, amendments to the Medical Practice Act relating to medical professional liability insurance. The major provision of these amendments was the deletion of that Section of Act 219 which required malpractice insurance coverage to obtain or retain a medical license. This feature of last year's law has been objectionable to HMA, and its deletion is most welcome. Ten other amendments were also signed into law which were supported by the HMA. These are listed in the May 16, 1977, special memo from President Cal Sia to HMA members.

Your Building Management Committee, assigned the responsibilities for looking after the affairs of our new home at 320 Ward Avenue, is happy to report that of the 21,601 sq. ft. of rental space, 19,993 is currently occupied, with all of the vacant space, except for 432 sq. ft. which it

will keep out for HMA expansion, expected to be occupied by the end of June.

The HMA Auxiliary needs to be given a very special "thanks" from the staff of the HMA. The HMA Auxiliary recently presented very special and thoughtful gifts to the HMA staff for its support during the past year. The staff wishes to express its deep gratitude; it is a pleasure to provide staff support to a wonderful group of people!

The Pacific PSRO is very heavily into its review activities in the medical community; it is officially bringing the bulk of acute care hospitals under PSRO review. The physicians involved in the PSRO program realize that such activities may seem to create some heavy burdens, not only on hospital personnel, but on physicians as members of hospital staffs. Please bear with them—it really isn't their fault!



Turning off the burner

The hospital-cost pot boileth over!

The President has said: "Let's clamp the lid on."

Then, we have a pressure cooker situation. We had a patient once, who drove herself all the way from the West end of Molokai, over rough and dusty roads, to the hospital at Ho'olehua to have her face burns treated—after hot spaghetti was peeled off with adherent skin. What happened? Her lid blew!

Do we reduce hospital personnel? Do we cut back the wages that have only lately been brought up to parity in the labor force? In other words, do we reduce personal services to patients? Maybe we should close hospital doors—or turn over the management to the government. The chorus of naves seems rather deafening, you say?

Impossible. And yet—there may be a way to reduce service without denying or reducing the quality of medical care in hospitals.

Hospitalization should be and usually is reserved for the acute care of illness or injury, or for elective but necessary surgical procedures that require more than office-type local anaesthesia. In all such instances, the care is intense but usually brief. With rare exceptions, the patient's condition improves; he becomes ambulatory, he feeds himself and he cares for his own bodily wants—though he may need some assistance and monitoring of his functions at first.

Why is it, then, so necessary to provide "room service" a la Royal Hawaiian Hotel, until the day he is discharged?

Why cannot the patient elect to have his choice of food (a diet recommended by his attending physician) brought to him by his family or by caterers? (It used to be an oriental custom for the family to bring in and set up a Hibachi!) Why cannot hospitals have a patients' dining room to which the patient "graduates" once he becomes ambulatory and tube-less?

By the same token, why not let family members come in, around the clock if need be, to attend and even to nurse the patient, under supervision, until he can care for himself? The hospital's daily rate could be reduced commensurate with the "free" food and service provided by outsiders in this way, and surely it is not beyond the capacity of the third party payors to figure out a way of supporting such a program by means of deductibles and credits, etc.

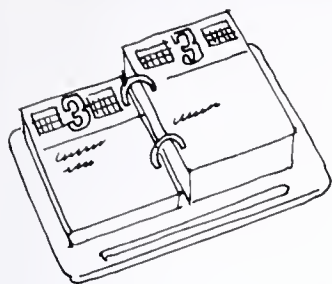
Finally—why is it that we physicians think nothing of instructing our out-patients in self-care and self-medication when they are confined at home by illness, yet in-hospital, the same patient with the same capabilities once he is over the acute stage is not even permitted to ask for or take an aspirin or a laxative or an enema or a shower or his usual and familiar battery of pills, without having a nurse spoonfeed it to him by-the-order? Even our difficulties with non-compliance at home is a problem easily managed in-hospital.

Just imagine a neat medicine cabinet on the wall by the headboard. It is kept locked (against monkey business). The patient has the key. Per schedule, easily posted and monitored, he takes his pills q.i.d. How much less likely is there a chance for error, as compared with "... this is for bed 2, room 210," a nameless non-person, whose pill box is lined up with those of all the other patients under the nurse's routine.

Fewer nurses? Yes, but less tedium for the one on duty.

It can be done, we say, and maybe it should be. Other ideas, anyone?

J.I.F.R.



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

(Contact CME Dept. for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
- Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
- Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
- Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room

3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professors' Program.

St. Francis Hospital

1. Medical Grand Rounds, Tuesday (4th & 5th) 12:30-1:30 p.m. Sull. IV Classroom
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
7. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu

Type: 1, 1 hr/day, 1 day/mo from 12 mos
Fee: None Methods: AV, O, Pan

Dates: All yr, 12 hrs instruction
 Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
 Type: 1, 1 hr/day, 1 day/mo for 8 mos
 Fee: None Methods: AV, Clin C, O, Pan, R
 Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

June 27, 1977 1:00 p.m., Obstetrics/Gynecology Conference, Q.M.C. Kam Auditorium, "Chemotherapy of Ovarian Carcinoma"—Kevin Loh, M.D. Discussion of current management and results of chemotherapy.

July 2, 1977 "The Sea around Us," Sat., 7:30 a.m., Kaiser Pac Aud., 1 hr. Cat. 1 credit, Searle & Co., contact Kaiser CME.

July 9, 1977 "Current Topics of Blood Banking," Sat., 7:30 a.m., Kaiser Pac. Aud., Julia Frohlich, M.D., Hawaii Blood Bank, 1 hr. Cat. 1. Contact: Kaiser CME.

July 14-15, 1977 "Pesticide Protection for Health Personnel," Univ. of HI, Manoa campus, 8:30 a.m.-4:00 p.m. Held at Bi-Med Sci. Bldg. T 208. 10 hrs. Cat. 1. Fee \$50. Sponsored by: U.S. Environmental Protection Agency-U of Miami Schl of Med. For more info contact: Lyle Wong, HI Epidemiologic Studies Program, 737-8811.

July 15-16, 1977 Conf. on Anaerobic Infections: Diagnosis & Management. Held at Mabel Smyth Aud. 510 So. Beretania, Honolulu. 9 hrs. Cat. 1. Contact: Queen's Med. Cntr. CME Dept. for further info.

July 16, 1977 "Venereal Disease Part II—Gonorrhea," Sat., 7:30 a.m., Kaiser Pac. Aud., Joel Brown, M.D., 1 hr. Cat. 1, contact Kaiser CME.

July 23, 1977 "Stroke Protocol," Jordan Popper, M.D. and Richard Korsak, M.D., Sat., 7:30 a.m., Kaiser Pac. Aud., 1 hr. Cat. 1, contact Kaiser CME.

July 30, 1977 "A Model for Brief Treatment of Common Sexual Concerns," Jack Annon, Ph.D. and Craig Robinson, Ph.D., Sat., 7:30 a.m., Kaiser Pac. Aud., 1 hr. Cat. 1, contact Kaiser CME.

August 6, 1977 "Development of Cardiovascular Surgery," David C. Sabiston, M.D., Professor and Chairman, Dept. of Surgery, Duke University School of Medicine, Sat., 7:30 a.m., Kaiser Pac. Aud., 1 hr. Cat. 1, contact Kaiser CME.

Aug. 8-21, 1977 Visiting prof. of Oncology, Am. Cancer Soc. HI Div. 200 N. Vineyard Blvd. Honolulu 96817. 10 days, 40 hrs. no fee. Ph. (808) 531-1662 for further info.

Aug. 11-22, 1977, 20th Annual Postgraduate Refresher Course. Univ. of So. Calif., Schl. of Med. 2025 Zonal Ave., LA 90033. Held at Honolulu, Maui, Kauai, Kona. 37 hrs. Phil R. Manning, M.D. Assoc. Dean.

Aug. 13, 1977 "Psychiatric Services in a Prepaid Medical Care Setting," William J.T. Cody, M.D., Sat., 7:30 a.m., Kaiser Pac. Aud., 1 hr. Cat. 1, contact Kaiser CME.

Aug. 20, 1977 "Newer Developments in the Treatment of Peptic Ulcer," Myron Lezak, M.D., Sat., 7:30 a.m., Kaiser Pac. Aud., 1 hr. Cat. 1, contact: Kaiser CME.

Aug. 28- World Psychiatric Association, Kathleen

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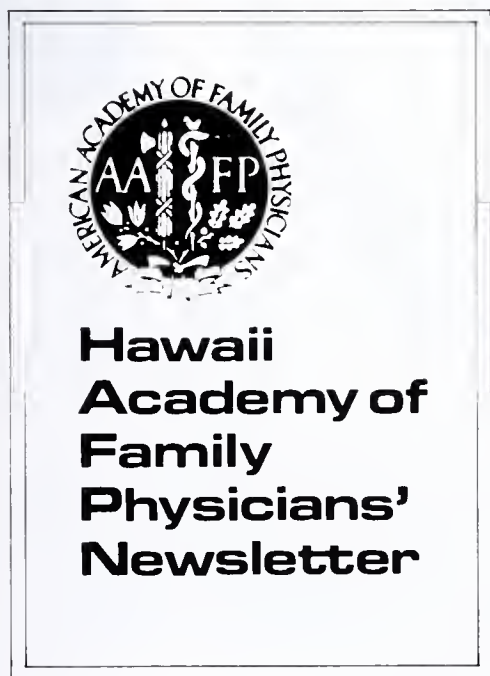
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Dept., 1700 18th Street, NW, Washington,
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Agent: Group Travel Unlimited.
- Oct. 31,
Nov. 4,
1977 HMA Annual Mtg.-AMA Regional, Sheraton-
Waikiki, Honolulu, Contact: Mrs. Bess Chang
-HMA 320 Ward Ave. S 200, Honolulu 96814
or (808) 536-7702.
- Nov. 2-5,
1977 American Academy of Neurological Surgery,
Dr. John Lowrey, 888 So. King St., Honolulu,
HI 96813. Hdq. Hotel: Mauna Kea Beach.
Agent: Not appointed.
- Dec. 5-9,
1977 Cardiology Seminar, Hawaii Conference
Services, P.O. Box 22670, Honolulu, HI
96822. Hdq. Hotel: Mauna Kea Beach.
Agent: Group Travel Unlimited

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1976 Supplement to JAMA or call the HMA Office.



New Members—Only one this time: **Nancy Morioka**, Student member, UHSM '81, is very welcome.

News of Members—**Don Burlingame**, Inactive member, has moved from Kailua, Oahu to Hilo on the Big Island. **Verne Adams**, who was practicing in Pahala before his move to North Carolina, is in litigation over the hospital records of his Big Island patients (Adv. 5/26/77).

History—The American Academy of Family Physicians celebrates its 30th birthday as of 10 June. It was born during the session of the American Medical Ass'n, its centennial meeting, at Atlantic City and hatched during the session of the AMA's Section of General Practice. Hawaii was represented at this organizational meeting, but we do not know who this person was. Perhaps a reader can fill us in. **Varian Sloan**, then a general practitioner in California, joined what was then called the A.A.G.P. in August of 1947; he transferred to the Hawaii Chapter in 1953. **Bill Walsh** joined AAGP in September 1948, from Hawaii, but the Hawaii Chapter was not formed until 1951. Bill was its first president.

CME—the Big One! USC-UH Schools of Medicine, jointly, 14-25 August at the Sheraton-Waikiki. In the Fall, it will be the AAFP 1977 Scientific Assembly in Las Vegas 10-13 October. For additional information contact the Hawaii Medical Association.



Friday, May 6, 1977, 5:30 p.m.

CALL TO ORDER

The meeting was called to order by President Calvin C.J. Sia. Also present were Drs. William Dang, Douglas Bell II, Grover Batten, Marion Hanlon, George Mills, Herbert Chinn, Ann Catts, William Kepler, Richard Lundborg, George Goto, J.I.F. Reppun, Leonard Howard, John Edwards, Calvin Kam, Rowlin Lichter, Sakae Uehara. Also present were Drs. Edgar Ho, Roy Kuboyama, Paul Condit, Thomas Cahill, Verne Waite, Reginald Ho, Attorney V. Thomas Rice and Mrs. Thomas Cahill.

MINUTES

The minutes of the April 1, 1977 meeting were approved as circulated.

REPORT OF THE TREASURER

The financial statement for the month ending March 31, 1977 was circulated and reviewed. The Treasurer noted that the Annual Meeting Income budget income for 1977 would be considerably less than anticipated due to the lowered registration fee approved by Council.

REPORT OF THE SECRETARY

The Secretary reported that as of April 30, 1977 the membership totalled 996. There are a number of delinquent members who either have not paid their dues or have not made their minimum contribution to the building fund. There are also 64 individuals who paid their membership dues but did not make the contribution to the building fund. There was considerable discussion regarding the procedures to be followed. According to HMA Bylaws, those who have not paid their dues or their assessed contributions by April 1 are notified of the delinquency and automatically forfeit membership after 30 days.

ACTION:

It was moved, seconded, and passed that the usual procedures be taken for those who have

not paid their dues or those who have not made their contribution to the Building Fund. It was also agreed that there would be no refund of dues for those who had failed to contribute to the building fund.

REPORT OF THE COMMITTEES AND COMMISSIONS

A. Medical Education: The Medical Education Committee presented a summary of their recommendations for CME Requirements for HMA Membership. The House of Delegates has voted that CME will be a condition for membership but did not set a specified date for starting the requirement. The CME Committee proposes that the program begin in 1979. The committee further recommends that a copy of HMA's recommendations be submitted to the Board of Medical Examiners, State of Hawaii, who are presently considering the CME requirements for licensure. The requirements for licensure are expected to become effective in 1980.

ACTION:

It was moved, seconded, and voted to approve the recommendations of the committee.

B. Hawaii Medical Library: Dr. John Watson, Chairman of the Board for the Hawaii Medical Library, thanked the Council for the contribution that had been made to the library for 1977 and briefly reviewed the fund-raising efforts for the library over the past six months. Dr. Watson noted that attempts are being made to seek support for the library from sources other than physicians as studies show the library is being used by nurses, the University of Hawaii, community college students, and the general public. He stressed the importance of looking at the future of the library operations and asked that members of the Council provide feedback to the Library Board during the coming year as to ways in which the library can become financially secure.

C. Auxiliary: Mrs. Thomas Cahill, representing the HMA Auxiliary, reported that the annual convention of the Auxiliary will be held on May 20 at which time the president of the National Auxiliary will be in Honolulu to attend the meeting.

D. Act 219 Committee: The ad hoc committee to Amend Act 219 presented their final report to the Council. The report outlined the summary of amendments to Act 219 which were passed by the State Legislature and the recommendations for changes in the law for the 1978 session.

ACTION:

It was voted to give Dr. Leonard Howard and the members of the committee a vote of thanks for the time spent in seeking amendments to Act 219.

E. Ad Hoc Committee on Self Insurance: Dr. Edwards reported that his committee was trying to arrange a symposium on professional liability insurance and alternatives to insurance but has had to postpone the seminar until a report has been received from one of the key participants. Dr. Sia noted that a meeting had been held with the insurance commissioner expressing the concern of the HMA regarding the proposed rate increase of Argonaut Insurance Company. The committee also plans to meet with several California carriers in the near future.

F. Cancer: Dr. Sia reported that a meeting had been held with UH President Fujio Matsuda, Dr. Douglas

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Yamamura, Dr. Lawrence Piette and representatives of the Hospital Association, Department of Health, and Cancer Society on April 19. The structure of the Cancer Center and the relationship of the Executive Board and the Executive Director was reviewed in detail and the executive functions of the Executive Board of the Cancer Center were reaffirmed. In view of the actions taken at this meeting, the Cancer Committee recommends that the Council revoke the committee's previous recommendation (April 1, 1977 Council meeting) regarding HMA withdrawal from the Cancer Center Executive Board.

ACTION:

It was voted to approve the recommendation of the Committee.

The Community Based Cancer Control Program was reviewed in detail and Dr. Dang reported that he had met with Dr. Ruby Isom of NCI to discuss HMA's concerns regarding certain portions of the project. Dr. Sia noted that the HMA notified the Director of the CBCCP, Dr. Robert Hasterlik, that there were concerns about the CBCCP which needed to be discussed prior to the submission of the program to NCI. A meeting of the CBCCP Council with HMA representatives was held on April 28. A few hours prior to the Council meeting, Dr. Hasterlik delivered portions of the CBCCP proposal to the HMA, especially those sections dealing with Data Collection and Information Systems; Rehabilitation and Continuing Care; and Detection, Diagnosis and Treatment. Dr. Condit and Dr. Batten reviewed these sections in detail. The project will be submitted to Washington on May 15.

ACTION:

It was moved, seconded, and voted to approve the principles of education and screening in the CBCCP; however, to go on record that the HMA disapproves the original proposal and cannot approve the revised protocol until HMA has had an opportunity to review the final proposal of the CBCCP in its entirety.

The Cancer Committee reviewed a draft of Cancer Center guidelines and recommended Council approval.

ACTION:

The guidelines were approved as printed below.

CANCER CENTER GUIDELINES

Preliminary guidelines were suggested in the report of the Cancer Committee dated September 3, 1976. Developments since then indicate that they need to be stated more explicitly.

The primary function of the Cancer Center is to serve as a community resource, providing techniques or consultation not available elsewhere in the community. It should be involved in the areas of basic research and epidemiology, but not intrude into patient care except as delineated below.

Cancer control programs involving screening are currently conducted in the community. The Cancer Center can assist these programs but not pre-empt them.

Patient care is the primary responsibility of the private physician; the Cancer Center plays no part in this process. Groups of physicians such as the Hawaii Oncology group, formed for cooperative and educational programs, may utilize procedures furnished by the Cancer Center, or may affiliate with a national oncology group, if desired.

The Cancer Center can make contributions by conducting and assisting careful studies in patients. Patients may be referred to specific programs by the private physician, who continues to care for the patient upon completion of the study. Patients who apply directly to the Cancer Center for care will be referred to their private physicians or to the appropriate County Medical Society.

Educational activities are not a primary function of the Cancer Center, and their participation in such programs should be in cooperation with sponsoring organizations (e.g., HMA, American Cancer Society, U. of H. Medical School, hospitals).

G. Cancer Commission: Copies of the minutes of the Cancer Commission meetings of April 13 and May 5 were circulated. The Commission reviewed the proposed Hawaii Tumor Registry Subcontract at its meeting of April 13 and made various recommendations to the Council regarding changes in the subcontract.

ACTION:

It was voted to approve the recommendations of the Commission regarding the language of the proposed subcontract for the Hawaii Tumor Registry. (A copy of the contract and proposed changes are on file in the HMA Office.)

ACTION:

The Council voted to accept the recommendation of the Commission to enter into negotiations for a direct NCI-HMA contract for the Hawaii Tumor Registry.

The Commission voted that the location of the Hawaii Tumor Registry is a matter for the HMA to decide and is not negotiable. In light of this recommendation, and since the Hawaii Tumor Registry is adequately housed at the present time and has enough room for expansion in the foreseeable future in its present quarters, it was moved that the HMA go on record stating that it does not plan to move the Hawaii Tumor Registry to the proposed building of the Cancer Center of Hawaii and that the HMA inform the President of the University of Hawaii of this action.

ACTION:

It was voted to approve the motion as proposed.

NEW BUSINESS

A. Mabel Smyth Board: Attorney V. Thomas Rice reported that the HMA has been served with a temporary restraining order and motion for a preliminary injunction by the Hawaii Nurses Association who has filed suit versus the HMA and Queen's Medical Center regarding the Mabel Smyth Building. Mr. Rice reviewed the details of the injunction and possible courses of action.

ACTION:

It was moved, seconded, and voted to retain Attorney V. Thomas Rice and to give Mr. Rice the authority to represent the HMA in court on Tuesday, May 10, and to enjoin the Mabel Smyth Board if necessary.

B. AMA CME Meeting in 1978: Mr. Won reported that the AMA is interested in presenting a CME Regional Meeting in Hawaii during 1978 similar to the one which will be presented in late 1977.

ACTION:

It was voted to proceed with plans for the meeting in 1978.

C. RV'S Suits: It was recommended that HMA write

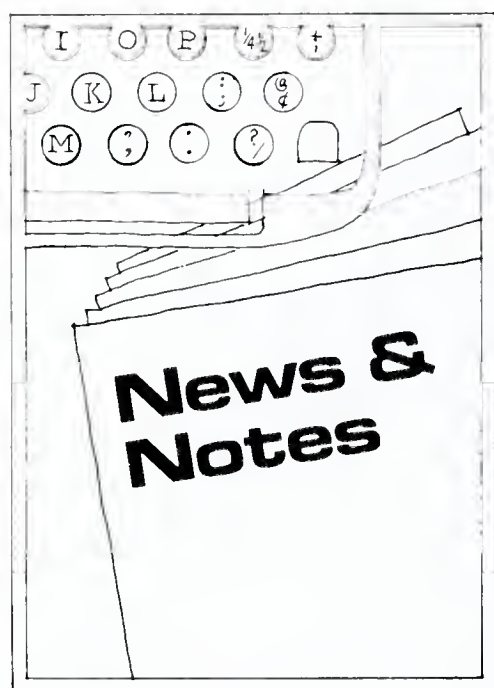
to Minnesota Medical Association and to the AMA regarding recent FTC suits against the use of RVS books.

D. Hiroshima Medical Association: Dr. Sia reported that a meeting had been held with members of the Hiroshima Medical Association extending an invitation to the HMA to become a sister association with their Association and to visit Japan to exchange a resolution of this affiliation. This matter will be explored further.

ADJOURNMENT

The meeting adjourned at 10:40 p.m.

DOUGLAS B. BELL II, M.D.
Secretary



HENRY N. YOKOYAMA, M.D.

Keeping The Upper Lip Stiff

"A striking lesson in keeping the upper lip stiff is given in a recent weekly bulletin of Federal Civil Engineering Contractors, which printed the following letter from a bricklayer in Barbados to the firm for whom he worked:

Respected Sirs:

When I got to the building, I found that the hurricane had knocked some bricks off the top. I rigged a beam and pulley at the top of the building and hoisted up a couple of barrels full of bricks. When I had fixed the building, there were a lot of bricks left over. I hoisted the barrel back up again and secured the line at the bottom. Then I went up and filled the barrel with extra bricks. When I got to the bottom and cast off the line, unfortunately the barrel of bricks was heavier than me and before I knew what was happening, the barrel started down, jerking me off the ground. I decided to hang on and halfway up, I hit the barrel coming down, receiving a severe blow to the shoulder. I continued to the top, banging my head against the beam and getting my fingers jammed in the pulley. When the barrel hit the ground, it burst its bottom, allowing the bricks to spill out. I was now heavier than the barrel and started down at high speed. Halfway down, I met the barrel coming up and received severe injuries to my shins. When I hit the ground, I landed on the bricks, getting painful cuts from the sharp edges. At this point, I must have lost my presence of mind, because I let go the line. The barrel came down giving me another heavy blow to my head and putting me in the hospital. I respectfully request sick leave." (Submitted by our friend and critic, **Sharon Bintliff**, the pediatrics professor)

Life In These Parts

"A new member of the Outrigger Canoe Club is a chap named **Barrister A. Richardson**, who's not a lawyer, but a surgeon . . . A case of parental dreams gone astray?" (Daacon, Honolulu Advertiser columnist)

"When CPA Len Mednick was in Kaiser for appendectomy, his surgeon was **Dr. Marcianno Aquino**. Now the doc is a client of Mednick, to receive tax slashes—the unkindest cuts of all . . ." (Also a Daacon quote)

Wasim Siddiqui, parasitologist at the UH Med School's Tropical Medicine Dept. has successfully immunized three Aotus monkeys against Plasmodium Falciparum. Wasim reported his results at a joint New York meeting of the World Health Organization and AID, but cautioned against unfounded optimism for the early development of a safe vaccine . . .

John Mebane, Hawaii County Mental Health Center director reports that his staff treats more than 1200 patients per month . . . John blames the poor state of economy on the Big Island for the situation . . .

Leslie Koch, state physician who flies into Kalaupapa twice a week to see the remaining leprosy patients in the colony describes the isolated Molokai peninsular as "Almost a Shangri-la, but with very little intellectual stimulation."

For over 12 years, cardiologist **Al Morris** has been told, "You know, you look just like Leonard Nimoy" (Spock, the half Vulcan). Prodded by son Danny, Al had his ears pointedly taped up and entered the Great Star Trek Look-Alike Contest at the Waikiki Shell . . . Al was described as having "more of the logical, emotionless, alien look about him" than other contestants . . .

Parker Ranch owner Richard Smart announced that his entire estate will go into a trust for the construction and maintenance of a hospital in Waimea to serve the South Kohala area. The new hospital will be attached to the new Lucy Henriques Medical Center and would grow in increments as needed . . .

It's good to see a happy **Bob Rose** finally walking sans full leg cast . . . Bob, as you remember, was hit by a car while bicycling in a bike path in Kuliouou over a year and a half ago . . .

"They had quite a good turnout at the Straub Alumni party which **Dr. Robert Flowers** prescribed the other night . . . Amazing the number of physicians who once toiled at the clinic that are now out on their own . . ." (From Dave Donnelly's column)

Psychiatrist **C. Stanard Smith**, originally from Texas and who has been a licensed Hawaii physician since 1963 had his license revoked by the State Board of Examiners for "gross carelessness and professional misconduct" in prescribing large amounts of amphetamines and narcotics to his patients . . . Smith has appealed the decision to the Circuit Court. Meanwhile he is training as a lay minister in a charismatic religious group here . . .

The new emergency suite at St. Francis Hospital opened in May . . . Head emergency physician **Douglas Ostman** is ecstatic because it is 5 times larger, has 15 beds instead of 3 and is equipped with an Xray room, a trauma and cardiac room that can be used as an emergency operating room, a minor surgery room, an ENT treatment room, a cardiac monitor room and an observation room . . .

Having noted those disconcerting deep creases in our own ear lobes, we wish to thank **George Rhoads**, **Keith Klein**, **Katsuhiko Yano** and **Henry Preston** for their article in the March issue of this Journal, entitled, "The Earlobe Crease—Sign of Obesity in Middle-aged Japanese Men." The article refutes the reports by both Sternlieb et al and Lichstein et al that a deep crease is indicative of coronary heart disease . . .

Professional Moves

Curiously enough, the past two months of April and May have been relatively quiet . . . In April, eye man **Gary Edwards** joined the Fronk Clinic, urologist **George Kenessey** joined **Rodman Miller** and the Haleiwa Medical Clinic Inc.

and internist **Tad Iwanuma** relocated to Suite 1040 Kapiolani-Children's Medical Center.

In May, child specialist **Roy M. Kaye** relocated to Suite 900 Kapiolani-Children's Medical Center and OB man **E. Duane Beringer** joined the Honolulu Medical Group . . . Perhaps this quiet is the eye of the typhoon?

On the Health Department front, psychiatrist **John Blaylock** who was interim chief of the Health Department Mental Health Division resigned effective July 1 saying "I feel I've served my time and want to do less hectic and more interesting work." John, as you remember, was caught in the maelstrom of the recent staff psychiatrists' contract negotiations . . .

Miscellany

Iconoclastic playwright George Bernard Shaw once sent two tickets to Winston Churchill with the following note: "Enclosed, find two tickets to my play's opening night. Please come with a friend if you have one." Winston returned the tickets with an equally barbed note: "Sorry, I can't make the opening night. But will be glad to attend the second night, if you have one." (As told by **George Suzuki** our tennis playing friend)

Dialogue from *Aku's* program: "We have a lady with 11 children and she wants to know how to stop . . ." "Have her take a glass of orange juice in the morning." "Before or after?" "Instead of . . ."

New song hit: "Who is the Lolo Who Stole My Pakalolo?"

Bulletins

"Pesticide Protection for Health Personnel" Two day seminar on recognition, management and prevention of pesticide poisoning on July 14 and 15 at U of H, Manoa Campus. Sponsored by a U.S. Environmental Protection Agency contract to the University of Miami School of Medicine and hosted by Pacific Biomedical Research Center. 10 credit hours Category I AMA Physician's Recognition Award. Sessions: 8:30 am to 3-4:00 pm daily at BioMedicalScience Bldg. T 208. Course fee: \$50.00 For registration and course information, contact **Lyle Wong**, Hawaii Epidermiologic Studies Program, Ph 737-8811.

Hawaii Medical Library: NCME video tapes made available by U of H Medical School. Also ENT Society donated video viewing facilities for tape viewing at the library. See John Breinick, head librarian for further information . . .

Best Bargain of the Year . . . The 3rd Annual Benefit Show held May 7 at the Ilikai Pacific Ballroom entitled "Happiness" starring Alan and Julie Grier, The Happiness Singers, Kauikeolani Keiki Chorus, the Floating Ribs, and Steve Hansen, the Puppet Man. Music by George Takushi's "The Torchers." A most delightful evening of entertainment arranged by master entrepreneur Ed Kagihara and co-workers . . . A must for next year . . .

Elected, Appointed, & Honored

Deputy Health Department director, **Audrey Mertz**, was elected president of the Hawaii Women's Political Caucus in May . . . **Sharon Bintliff**, pediatrics professor and birth defects clinic director, has been appointed to the 18-member National Advisory Committee of the Food & Drug Administration . . . **George Starbuck**, assistant professor of pediatrics and medical director of the Children's Protective Services Center, was honored by the Honolulu Police Dept. for his work with child and sex abuse victims. George lectures on child and sex abuse to police recruits and is credited with the establishment of the Crisis Center and the new Sex Abuse Treatment Center . . . **Michael Okihiro** was named Alumnus of the Year by the Mid Pacific Institute Alumni Association. Mike is physician for the Pac 5 team and three of his 5 children graduated from his Alma Mater . . . **David Woo**, retired Hilo physician, was honored by the Chinese Civic Association of Hawaii in Hilo at a banquet. David plans to retire in Honolulu . . . Kauai physician **Patrick Aiu** was appointed to the Board of Medical Examiners and **Peter Kim**

was appointed to the Kanai County Hospital Management Advisory Committee . . . Two leading dissidents of the Kona Hospital medical staff, **Allan Hubacker** and **James Mayer**, were elected chief and vice chief of staff respectively . . . **Ben Kamarudin Azman** of Lahaina was named a diplomat of the American Board of Family Practice . . .

Sportsmen

The Case For Jogging Shoes . . .

At the 4th Session of the Pan Pacific Surgical Association's special seminar on trauma, orthopedist **Robert Smith** reported on increased knee, foot, ankle and hip complaints among joggers caused by the constant pounding, improper shoe fittings, foot imbalance and improper training . . . Bob feels that different feet or different kinds of running require different shoes and recommends "the best way to find out about the type of shoe is to ask a seasoned runner or runners who sell shoes . . ." He also recommends consulting the "Runner's World" magazine's shoe issue . . .

Chuck Probst, Kahului physician, long distance runner and Maui medical adviser for the 1977 March of Dimes Walkathon says, "Zoris, thongs, deckers, sandals—call them what you will—are definitely out. Some very nasty looking blisters have been caused by this foot wear in previous years." Chuck recommends hiking shoes, tennis shoes or jogging shoes, but esp. the latter . . .

Sports Bulletin . . . Former HMA president **Bill Dang** did not win the recent DDD Tournament . . . Bill shot a 95-19-76 and did not even place . . . And it wasn't as if he did not try, for Bill played the Hawaii Kai course twice weekly for a month and a half in preparation . . . It seems that our perennial winner had trouble with water hazards and OB's for a total of 8 penalty strokes . . .

Bill says, "The pharmacists ran away with everything including the tennis tournament . . ." i.e. all except 1st place in B Flight which old tiger **Al Paraz** won . . . It appears that pharmacists **Roy Tanabe** and **Wally Soon** shot net 66's to take both overall low net and C Flight 1st place . . .

Hawaii Bound . . . Two adventuresome physicians, **John Corboy** and **Nadine Bruce**, have completed the 5 day executive courses of Hawaii Bound which is designed for adults with limited time and who need the change in pace. These Hawaii Bound short courses include back packing in the mountains, outrigger canoeing, training in basic wilderness skills, emergency care and even rappelling . . . Those interested should write c/o Hawaii Bound, P.O. Box 1500, Kailua, Hawaii 96734 or call 262-6988 . . .

Golfers . . . On Stag Day at Mid Pac CC, **Victor Mori** had a hot streak and shot 4 eagles to spark his threesome including **Namoritsu Tajima** and **Masa Koike** to a 14 under 3rd place tie with another physician trio of **Frank Fukunaga**, **Ed Izawa** and **Bob Oishi** . . .

Visiting Professors

William Longmire, professor of surgery at UCLA School of Medicine, was here for 2 weeks and lectured on gastric CA, varicosities, lesions of the liver, bile duct, pancreas and on hepatic resection. Herein are excerpts from his "Current Ideas on the Management of Cancer of the Stomach" as submitted by **Pill Hong**, Kuakini director of surgical education: "Striking decline in incidence of stomach cancer in the U.S. . . . i.e. from 30/100,000 population in 1930 to 10/100,000 in 1970 . . . whereas lung CA has risen from 5/100,000 to 40/100,000 during the same interval . . . Still the 4th greatest killer among malignancies in men . . . Radical surgery has not changed the 5 year survival . . . The results of surgical treatment are no better than 10 years ago . . . I feel that a conservative approach is justified since we are dealing with a systemic disease . . . We are all aware of the capricious nature of this disease even when cancer is left at surgery . . . The excellent results in Japan (95% 5 year survival when tumor is confined to the mucosa) is the result of two excellent techniques . . . viz their double contrast X-ray studies and their use of endoscopy . . . I advocate a philosophical approach, i.e. extent of life vs. quality of life . . .

During his lecture on hepatic resection, William commented on chemotherapy via IV cannulation of the Hepatic A. for primary malignant liver cancer: "We put the patients through quite an ordeal without substantial results . . . I wonder . . ."

UC pediatric hematologist and visiting KCH professor, **Louis Diamond**, lectured on breast feeding and Fe deficiency anemia: "A 10 state survey showed Fe deficiency anemia in all racial groups, all economic groups and beginning way back at the beginning viz with breast feeding . . . When William Osler was president of the American Pediatric Society, he once said, 'Breast feeding is once again becoming popular' . . . Feel a person's nose . . . If there is a split in the cartilage, you are a breast fed baby . . . As pediatricians, you do not need to be pushed on breast feeding . . . but we should assist the obstetricians . . ."

Gilbert Gordon, endocrinologist from UCSF, lectured on postmenopausal osteoporosis at a QMC Friday morning conference. The following are highlights of his lecture: Estrogen is effective in preventing bone loss and the risk is minimal . . . Both menopausal and castrated women have a linear loss of bone mineral . . . It is a myth that osteoporosis is a self limited disease . . . Estrogen prevents osteoporosis and restores partial osteoporosis . . . Properly given and properly administered, estrogen has no risk factor . . . r.e. Endometrial CA: Hollywood series risk factor 7.9% . . . Actual risk factor 0.009%.

Miscellany

A doctor, a lawyer and an accountant were having a heated argument about whose hunting dog was the smarter . . . Finally they decided to have a contest and they met at the doctor's home . . . The doctor called to his dog, "Stethoscope, go into the kitchen and get 6 dog biscuits . . ." Stethoscope promptly obeyed and lined up the six dog biscuits in a neat straight line . . . The accountant called to Calculator his dog and ordered, "Fetch a dozen dog biscuits and divide them into 3 piles . . ." Calculator did so with remarkable facility . . . The lawyer looked on the demonstrations with characteristic disdain and whispered to his dog: "Loophole, go show them what you can do." Loophole gobbled up all the biscuits with dispatch and promptly screwed both his opponents . . . (As told to **George Suzuki** by our Medrol man, **Richard Bell** . . .)

Conference Notes

Grant Stemmerman reports that fellow Kuakini pathologist **Frank Fukunaga** has found the organisms in the acute gall bladder to be identical to those in the colon in post cholecystectomy wound abscesses . . . Stemmy recommends that cultures be taken from the diseased gall bladder at time of surgery since any subsequent wound abscesses may be caused by the same organisms . . .

A 63-year old Filipino man, a Jehovah's Witness, had consistently refused surgery for his rectal tumor since 1975 . . . The patient even journeyed to Mexico for faith healing and returned with symptoms of acute obstruction. At exploratory lap, the patient had a constricting lesion of the colon at the level of the peritoneal reflection, but the chief cause of his symptoms was a perforated appendix . . . The patient could have had his own blood transfused back to him by sending previously drawn blood to San Francisco for freezing and storage until needed . . .

At a KCH Monday noon conference, **Sheryl Hammar**, director of the KCH Obesity Clinic gave an interim report and made some interesting observations: "The average age of referral clinic patients was 13.4, the age range 10-20 years, and the average duration of obesity 7.8 years . . . Referrals were 36% caucasians, 41% mixed, 18% Japanese, and 5% Chinese and very curiously very few Samoans . . . Onset of obesity: infancy 30%, preschool 17%, schoolage 47% and adolescence 2% . . . Characteristics of obese children: (1) Long standing obesity is associated with advanced puberty (average age of menarche is 11.5 or 1 year earlier). (2) Average caloric intake: 2,000 calories/day (which is not much more than for non-obese children . . . Obesity once established does


not require much to maintain). (3) Social isolation: 25% have a single friend and another 25% have no friends. (4) Exercise: none . . . Problems encountered: Adolescence is too late . . . Must start in infancy . . . Encourage 6 to 9 months of breast feeding and delay introduction of solids . . . Monitor weight carefully and interfere early . . .

Dialogue from the UH Grand Rounds on Colon Rectal CA . . .

Kuakini pathologist **Grant Stemmerman** was enthusiastic: "Within 2 years, we'll identify the specific carcinogen in colon-rectal CA . . . I'm just now getting excited . . . We'll put you surgeons out of business . . . There is a definite geographic difference of frequency . . . Colon-rectal CA is definitely an environmentally derived disease . . ." Stemmy's hypothesis . . . "Nitrites from diet, saliva, etc. at low pH in the stomach combine with secondary amines (proline) to form nitrosamines. These nitrosamines through the action of bacterial exchange enzymes in the colon become mutagenic nitrosamides which in turn transform colon cells into cancer cells. A suppressor enzyme when present in the colon can convert the mutagenic nitrosamides into non-mutagenic products . . ."

Results from the Japan-Hawaii Cancer studies:

	Nitrosamine/Amide Exchange Enzyme		
	Fecal Mutagens	in Fecal Bacteria	Suppressor Enzyme
Hawaii Japanese	50 %	55%	14%
Northern Rural Japanese	22.7%	10%	72%



**Clinical
Pathologist's
Easy Chair**

FRANCIS FUKUNAGA, M.D.

Electron Microscopy

Electron microscopy, usually considered a research tool, can also be of great diagnostic value to the pathologist and clinician. It is essential for the diagnosis of certain renal diseases, of some tumors, and of some hematologic, gastroenterologic, virologic and metabolic diseases.¹

The electron microscope can help establish the diagnosis early in the course of renal diseases such as idiopathic nephrotic syndrome, amyloid nephrosis, and early diffuse diabetic glomerulosclerosis.² Increased use of the electron microscope has revealed new pathologic lesions that allow improved diagnostic differentiation and a means of evaluating therapy. Some lesions,

continued on page 188

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such as chronic progressive hereditary nephritis and nail-patella syndrome, may be diagnosed only with the electron microscope.

In the diagnosis of tumors, where light microscopy fails or is equivocal, the electron microscope has been valuable.³ The absence of cell membrane specialization is characteristic of lymphoreticular tumors and is therefore helpful in differentiating anaplastic carcinomas from reticulum cell sarcoma.

Certain lesions have characteristic secretory granules, such as mucin granules in adenocarcinomas, lysosomal granules in prostatic carcinoma, and melanin granules in melanomas. There are also certain characteristic cytoplasmic organelles in some tumors. Some authors feel that the effects of chemotherapy can best be assessed by the ultrastructural study of the cell.⁴

The hematologist is finding increased use for electron microscopy. He is able to study the basic defects of erythrocytes in various anemias. Ultrastructural study of platelets is helpful in some platelet disorders. The electron microscope has been useful in distinguishing acute promyelocytic leukemia from other leukemias.

The gastroenterologist can see specific lesions that are important for the diagnosis of Whipple's disease, non-tropical sprue, and amyloidosis, by electron microscopy.

The electron microscope can establish the family to which a virus belongs and the use of viral antibody complexes will allow further definitive identification.

Some storage diseases, such as Fabry's disease, can be identified ultrastructurally. The study of peripheral capillaries in the late stages of diabetes mellitus provides a means of detecting widespread capillaropathy, the two most significant manifestations being retinopathy and neuropathy.⁵

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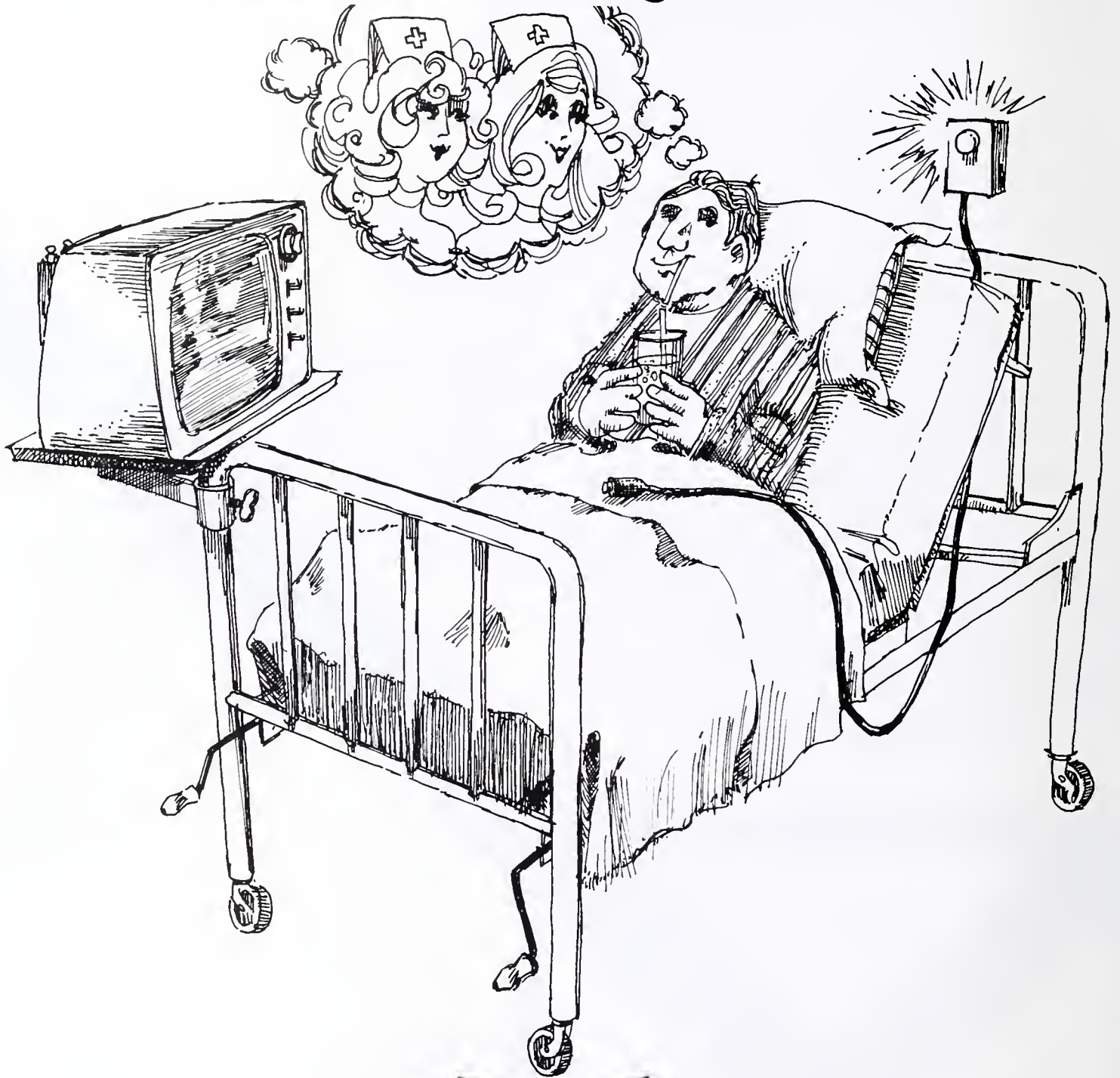
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Valium (diazepam) is a benzodiazepine with a character all its own.

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Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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memo

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The vulnerable ages

The first epileptic seizure is most likely to occur during early childhood and at the onset of puberty

About 9 out of 10 epileptics experience their first seizure before the age of 20—with the highest incidence between 5 and 7, when children start school, and at the onset of puberty, a time of physiological and psychic turmoil.¹ The most common type, grand mal, occurs in approximately 75% of epileptic children,¹ and more than 50% of patients who suffer initially from petit mal develop grand mal seizures before they reach the age of 16.²

Mysoline (primidone) for control of grand mal, psychomotor and focal epilepsy

At the onset and afterwards—used alone or as concomitant therapy, MYSOLINE may reduce the frequency and severity of major motor seizures—or even eliminate them. *Excellent* for control of grand mal. Valuable for control of psychomotor^{1,3,4} and focal epilepsy as well.⁵

Add Mysoline when control with other anticonvulsants is inadequate—As concomitant therapy, MYSOLINE can improve seizure control in grand mal and psychomotor epilepsy. The combined use of phenobarbital, diphenylhydantoin, and MYSOLINE may have additive anticonvulsant effects without additive side effects.⁶

Change to Mysoline when other anticonvulsants fail—A changeover to MYSOLINE is frequently warranted when other anticonvulsants must be discontinued because of important side effects, or when grand mal seizures are refractory to phenobarbital, with or without diphenylhydantoin.⁷

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BRIEF SUMMARY

(For full prescribing information, see package circular.)

MYSOLINE® Brand of PRIMIDONE Anticonvulsant

ACTIONS: MYSOLINE acts on the central nervous system to raise seizure threshold or alter seizure pattern. The mechanism(s) of action of anticonvulsant drugs is not known.

Primidone has anticonvulsant activity *per se*. In addition, its two metabolites possess anticonvulsant qualities. The major metabolite is phenylethylmalonamide (PEMA); the other is phenobarbital. In addition to its own anticonvulsant potential, PEMA potentiates phenobarbital.

INDICATIONS: MYSOLINE, either alone or used concomitantly with other anticonvulsants, is indicated in the control of grand mal, psychomotor, and focal epileptic seizures. It may control grand mal seizures refractory to other anticonvulsant therapy.

CONTRAINDICATIONS: Primidone is contraindicated in: 1) patients with porphyria and 2) patients who are hypersensitive to phenobarbital (see ACTIONS).

WARNINGS: The abrupt withdrawal of antiepileptic medication may precipitate status epilepticus.

The therapeutic efficacy of a dosage regimen takes several days before it can be assessed.

Use in pregnancy: Recent reports strongly suggest an association between the use of anticonvulsant drugs by women with epilepsy and an elevated incidence of birth defects in children born to these women. Reference has been made to primidone in several cases in which it was used in combination with other anticonvulsants; but its teratogenicity has not been conclusively demonstrated. The possibility exists that other factors, e.g., genetic factors or the epileptic condition, may contribute to the higher incidence of birth defects. The data also indicate that the great majority of mothers receiving anticonvulsant medication deliver normal infants.

Anticonvulsant drugs should not be discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and risk to both mother and the unborn child.

When the nature, frequency, and severity of the seizures do not pose a clear threat to the patient, good medical practice requires that the physician weigh the expected therapeutic benefit of anticonvulsant therapy against possible risk on an individual basis.

Neonatal hemorrhage, with a coagulation defect resembling vitamin K deficiency, has been described in newborns whose mothers were taking primidone and other anticonvulsants. Pregnant women under anticonvulsant therapy should receive prophylactic vitamin K₁ therapy for one month prior to, and during, delivery.

The physician should weigh all of the foregoing considerations when treating and counseling epileptic women of childbearing potential.

PRECAUTIONS: The total daily dosage should not exceed 2 Gm. Since MYSOLINE therapy generally extends over prolonged periods, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

In nursing mothers: There is evidence that in mothers treated with primidone, the drug appears in the milk in substantial quantities. Since tests for the presence of primidone in biological fluids are too complex to be carried out in the average clinical laboratory, it is suggested that the presence of undue somnolence and drowsiness in nursing newborns of MYSOLINE-treated mothers be taken as an indication that nursing should be discontinued.

ADVERSE REACTIONS: The most frequently occurring early side effects are ataxia and vertigo. These tend to disappear with continued therapy, or with reduction of initial dosage. Occasionally, the following have been reported: nausea, anorexia, vomiting, fatigue, hyperirritability, emotional disturbances, sexual impotency, diplopia, nystagmus, drowsiness, and morbilliform skin eruptions. Occasionally, persistent or severe side effects may necessitate withdrawal of the drug. Megaloblastic anemia may occur as a rare idiosyncrasy to MYSOLINE and to other anticonvulsants. The anemia responds

to folic acid, 15 mg. daily, without necessity of discontinuing medication.

DOSAGE AND ADMINISTRATION: The average adult dose is 0.75 to 1.5 Gm. per day. The initial dose is 250 mg. Increments of 250 mg. are added, usually at weekly intervals, to tolerance, or therapeutic effectiveness, up to daily doses not exceeding 2.0 Gm. A typical dosage schedule for the introduction of MYSOLINE (primidone) is as follows:

Adults and Children Over 8 Years of Age

1st Week 250 mg. daily at bedtime	2nd Week 250 mg. b.i.d.
3rd Week 250 mg. t.i.d.	4th Week 250 mg. q.i.d.

In children under 8 years of age, maintenance levels are established by a similar schedule, but at one-half the adult dosage. It is best to begin with 125 mg., with gradual weekly increases of 125 mg. a day, to a daily total usually between 500 mg. and 750 mg.

In patients already receiving other anticonvulsants: MYSOLINE should be gradually increased as dosage of the other drug(s) is maintained or gradually decreased. This regimen should be continued until satisfactory dosage level is achieved for combination, or the other medication is completely withdrawn. When therapy with this product alone is the objective, the transition should not be completed in less than two weeks.

MYSOLINE 50 mg. Tablet can be used to practical advantage when small fractional adjustments (upward or downward) may be required, as in the following circumstances:

- for initiation of combination therapy
- during "transfer" therapy
- for added protection in periods of stress or stressful situations that are likely to precipitate seizures (menstruation, allergic episodes, holidays, etc.)

HOW SUPPLIED: MYSOLINE Tablets—No. 430—Each tablet contains 250 mg. of primidone (scored), in bottles of 100 and 1,000. Also in unit dose package of 100. No. 431—Each tablet contains 50 mg. of primidone (scored), in bottles of 100 and 500. MYSOLINE Suspension—No. 3850—Each 5 cc. (teaspoonful) contains 250 mg. of primidone, in bottles of 8 fluid-ounces.

References: 1. Livingston, S.: Comprehensive Management of Epilepsy in Infancy, Childhood and Adolescence, Springfield, Ill., Charles C Thomas, 1972, pp. 6, 7, 584. 2. Grossman, H.J., III. Med. J. 135:260 (Mar.) 1969. 3. Scholl, M.L., in Conn, H.F.: Current Therapy 1973, Philadelphia, Saunders, 1973, pp. 675-7. 4. Metrick, S.: C.M.D. 37:49 (Jan.) 1970. 5. Forster, F.M.: Med. Clin. North Am. 47:1579 (Nov.) 1970. 6. White, P.T.: Wis. Med. J. 68:178 (Apr.) 1969. 7. Millichap, J.G.: Drug Ther. 1:15 (Oct.) 1971.



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A photograph of a woman from the chest up, shown in profile against a dark background. She has dark hair and is looking down. Her left hand, with red nail polish, is resting on her right shoulder. On her right shoulder, there is a large, irregular, white, scaly patch of skin, which is a clinical sign of allergic dermatosis. The text "Allergic Dermatoses..." is overlaid in white on the lower right portion of the image.

Allergic Dermatoses...

Contraindications: Hypersensitivity to hydroxyzine. Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit; induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate to establish safety in early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy.

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An Overview of the Renal Recipients in Hawaii: August, 1969 - February, 1975

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● *During the "black years" of kidney transplantation, with development of techniques in their infancy, failure and death rates were high. By 1963, when immunosuppressive drug use was just beginning, 194 renal transplants had been reported in the literature. Of this number, fewer than 10% of the 103 non-twin transplants survived more than 3 months.⁸ Today, however, the outcome of kidney grafts with patients suffering from end-stage renal disease is considerably brighter, and renal transplants surpass clinical transplants of any other human organ.⁶*

The present investigation presents an overview of the renal recipients in the state of Hawaii. The report is divided into two parts: a) information related to the total patient group whose renal transplants were performed in Hawaii from August, 1969, to February, 1975; and b) additional data obtained from a surviving group of renal transplant recipients.

Total Renal Recipient Group

In August, 1969 the first 3 renal grafts were performed in Hawaii within 6 days of each other. All 3 of the recipients were males whose kidneys were donated by immediate family members. One of the grafts eventually failed to function, and the patient died approximately 2 months

after receiving a second transplant (cadaveric) in 1971. Today, more than 6 years after these initial operations, the other 2 recipients are being sustained by their transplants and are leading active, normal lives. After 18 months, and 14 transplants using immediate family donors, the first cadaveric renal transplant was performed in February, 1971.

As of February, 1975, a total of 77 renal transplants were performed in Hawaii, 34 (40.3%) using related donors and 46 (59.7%) using cadaveric donors. Seven of the total were second transplants for individuals whose first transplants had failed to function.

The survival rate for the total renal transplant group was 77.1% for the first year, 69.9% for the second year, and 67.6% for the third year. However, in keeping with the results reported in the literature,^(4, 11, 14) the survival rate for related donor transplants was better than that for cadaveric donor transplants. The first year survival rate for the Hawaii renal recipients with related transplants was 93.5%, decreasing to 86.0% for both the second and third years. The first year survival rate for cadaveric renal recipients was 64.1%, then 57.0% and 51.3% for the second and third years, respectively.

A larger percentage of patients with cadaver kidneys died (Table 1) or returned to dialysis because of non-functioning grafts, while related transplant patients more often enjoyed functioning grafts. Using the chi square, the association between donor source and kidney status was significant at the .01 level.

The sex ratio of the Hawaii renal recipients was 2:1, or 46 males to 24 females. The oldest recipient at the time of transplantation was a man 63.3 years old; the youngest patient was a 2.7-year-old child. Table 2 presents the age at transplantation by decades for recipients of both related and cadaveric transplants. The largest number of transplants was performed on individuals in their 20's and 40's. Kidney transplants were rarely performed on patients under 10 years old or past 60.

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Note: This report is based on a portion of the first author's doctoral dissertation.

In the year following this report, 10 additional renal grafts were performed in Hawaii, 2 living related and 8 cadaveric transplants.

TABLE 1.—*Status of Renal Transplantation in Hawaii as of February 25, 1975*

STATUS OF RENAL RECIPIENTS	RELATED TRANSPLANTS	CADAVERIC TRANSPLANTS	TOTAL TRANSPLANTS
Living with functioning kidneys	22 (71.0)	10 (25.6)	32 (45.7)
Living on dialysis	5 (16.1)	12 (30.8)	17 (24.3)
Deceased	4 (12.9)	17 (43.6)	21 (30.0)
Total first transplants per individual performed in Hawaii	31 (100)	39 (100)	70 (100)

Note. Numbers in parentheses indicate percentages.
From February, 1971 to February, 1975, seven patients whose transplants failed to function underwent a second transplant operation (three with related transplants and four with cadaver transplants the first time). Four of the seven second transplant recipients returned to dialysis and three died. Including second transplants, a total of 77 transplants were performed in Hawaii.

TABLE 2.—*Age at Transplantation by Decades for Recipients of Renal Transplants Performed in Hawaii*

AGE BY DECADES	RELATED TRANSPLANTS	CADAVERIC TRANSPLANTS	TOTAL TRANSPLANTS
Under 10	1 (3.2)	1 (2.5)	2 (2.9)
10 - 19	3 (9.7)	5 (12.8)	8 (11.4)
20 - 29	16 (51.6)	8 (20.5)	24 (34.3)
30 - 39	4 (12.9)	4 (10.3)	8 (11.4)
40 - 49	6 (19.3)	14 (35.9)	20 (28.6)
50 - 59	1 (3.2)	6 (15.4)	7 (10.0)
60 - 69	—	1 (2.6)	1 (1.4)
Total	31 (100)	39 (100)	70 (100)

Note. Numbers in parentheses indicate percentages.

TABLE 3.—*Age at Initial Hemodialysis, First Transplant, and Transplant Waiting Period of Recipients of Renal Transplants Performed in Hawaii*

	RELATED TRANSPLANTS	CADAVERIC TRANSPLANTS	t-TEST	DEGREES OF FREEDOM	PROBABILITY
Mean age (years) at initial hemodialysis	27.6 (10.3)	34.4 (14.6)	2.2	68	<.05
Mean age (years) at first transplant	28.6 (10.3)	35.9 (14.8)	2.3	68	<.05
Mean length (months) of transplant wait ^a	11.7 (10.5)	18.1 (13.7)	2.1	67	<.05

Note. Numbers in parentheses indicate standard deviations.
^a No data for one related transplant.

The mean ages of the 70 renal recipients at their first transplant and initial dialysis were 32.7 years and 31.4 years, respectively. An average of 15.3 months was spent during the transplant waiting period (i.e., between onset of hemodialysis and transplantation date). Table 3 indicates that the recipients with cadaveric kidneys tended to be older than the recipients with related donor organs at the time of initial hemodialysis. The age difference was significant at the .05 level using the *t*-test. Cadaveric transplant recipients were also significantly older (*t*-test = *p*<.05) than related transplant recipients

at the time of transplantation. Furthermore, patients with cadaveric organs waited significantly longer (*t*-test = *p*<.05) for a transplant after dialysis treatments were started than did their counterparts with related organs.
In overall terms, the recipients of renal transplants performed in Hawaii resembled the population of renal transplants reported to the international Transplant Registry. At both the state and world-wide levels, more males than females underwent renal surgery, and these procedures utilized a larger number of cadaveric than related organ donations. Younger individuals were

more often candidates for transplantation, and, except for infants, patients younger than 30 years tended to receive kidneys from family donors, while patients older than 30 more often received cadaveric transplants. In Hawaii, patients younger than 30 constituted 64.5% of the related transplant group, but only 35.8% of the cadaveric transplants. The association between donor source and age (30 years or younger; 30 plus years) was significant at the .05 level using the chi square.

Why were the recipients of cadaveric organs older than their counterparts with related donor kidneys? The answer is related to the circumstances surrounding the process culminating in transplantation. Although the donation decision was resolved in an individual manner in each family, the problem was approached soon after the diagnosis of chronic renal failure was made, and the question of whether a suitable donor could be located in the clan was settled not long after that. If a donor was found within the family, the transplant was usually performed as soon as possible. Hemodialysis was used as an interim device to prepare the patient for a transplant until all medical tests for donor and recipient were completed. Individuals who had to rely on a cadaveric graft faced a longer period on dialysis: an organ had to be available under optimal conditions (generally death from cerebral causes or accidents in a hospital setting to insure the kidney was in good condition); the organ's blood and tissue types had to match those of the

recipient to reduce the chances of rejection; finally, permission to utilize the organ as an anatomical gift had to be secured. Younger individuals were more likely to receive kidney grafts from within the family because their parents and siblings, the most probable donation sources, also tended to be young and medically good candidates for the surgical procedure. Once a person reached mid-adulthood, his parents and older siblings dropped out of the donation pool because of age and health reasons. Thus, the probability that an older person would have a cadaveric transplant, and a longer period on dialysis while waiting for a transplant, was greater than that for a younger person.

The critical period for a transplanted kidney (i.e., date of transplant to date of death or removal of graft) was, on the average, 5.1 months. Some patients died or had nephrectomies performed a few days following transplant surgery, while these critical instances did not occur for other patients for over a year after transplantation. The 21 patients who expired after receiving renal transplants survived an average of 4.7 months after their initial transplant operation. The seven patients who received second kidney grafts spent a mean of 12.7 months waiting for a second transplant. This second waiting period was calculated from the date of nephrectomy to the second transplant date.

Donor information relating to the renal transplants is outlined in Table 4. Within the related donor group, siblings (67.7%) were the largest

TABLE 4.—Donor Information for Recipients of Renal Transplants Performed in Hawaii

DONOR INFORMATION	RELATED TRANSPLANTS	CADAVERIC TRANSPLANTS ^a	TOTAL TRANSPLANTS
Sex of donor ^b			
Male	12	25	37
Female	19	20	39
Total	31	45	76
Age of donor ^c			
Mean age	32.5 (12.9)	26.6 (16.3)	28.7 (15.0)
Relation of donor to recipient			
Mother	8	—	8
Father	1	—	1
Brother	10	—	10
Sister	11	—	11
Son	1	—	1
Daughter	—	—	—
Unrelated	—	46	46
Total	31	46	77
Ethnicity of donor ^d			
European	10	22	32
Asian	12	11	23
Other	9	12	21
Total	31	45	76

Note. Numbers in parentheses indicate standard deviations.

^a Cadaveric transplants include both first and second transplants performed.

^{b,d} No data for one cadaveric transplant.

^c No data for two related and two cadaveric transplants.

donor source. Mothers were also a frequent donor source, but fathers and children seldom donated their kidneys. Within the cadaveric transplant group, whites contributed about twice as many organs as did either orientals or "other" ethnic groups.

The U.S. Kidney Transplant Fact Book¹² reported cadaveric kidneys constituted the largest donor pool (51.2%), followed by parents (21.0%), and siblings (20.8%). In Hawaii, cadaver kidneys were used for 59.7% of all transplants performed, including both first and second transplants. Siblings (27.3%) donated organs more frequently in Hawaii than did parents (11.7%).

Interview Group

In-depth interviews were conducted with 42 renal recipients, 25 males and 17 females. Only 2 of the 42 patients did not have their transplants performed in Hawaii. There were 23 related transplants and 19 cadaveric transplants among the interview group (Table 5). These patients represented 93.3% of all living renal transplant recipients residing on the island of Oahu, and ranged from 12.7 to 60.9 years of age at the time of the interviews. Six of the 51 total living recipients whose transplants were performed in Hawaii (11.8%) were now residing in other states, or on one of the other Hawaiian islands; and, therefore, were not included in the present investigation. Three patients (5.9%) declined to participate in the study.

The mean age of the subjects interviewed was 30.1 years at the time of initial dialysis and 31.3 years at the time of transplant. Although the waiting period for the graft varied from less than a day (an identical twin was operated on immediately after her first dialysis) to more than 3 years, the mean waiting period for the interview group was 15.0 months. Cadaveric transplant recipients underwent a longer mean waiting period and tended to be older at the time of first dialysis and transplantation than related transplant recipients (Table 6). The differences between donor source and dialysis age, transplantation age, and waiting period were not significant for the interview group using the *t*-test. These differences, however, were significant for the population of renal transplants performed in Hawaii reported earlier. Among the total cadaveric transplant group, the mortality rate was high, and the non-survivors tended to be older and to have had a longer mean waiting period. The effect was a lowering of the ages and waiting period for the surviving cadaveric recipients in the interview group. However, as Table 7 indicates, the age and waiting period differences between the total cadaveric and interview groups and the total related and interview groups were not significantly different.

Table 8 depicts the ethnic composition of the renal recipients interviewed. The patients were most often a mixture of ethnic heritages (i.e., two or more ethnic groups), followed by those of Japanese and European ancestries. Among

TABLE 5.—Derivation of the Interview Group from the Total Living Renal Transplants Performed in Hawaii

	RELATED TRANSPLANTS	CADAVERIC TRANSPLANTS	TOTAL TRANSPLANTS
Renal recipients interviewed ^a	23 (79.3)	19 (86.4)	42 (82.3)
Renal recipients not interviewed			
Recipients off Oahu	4 (13.8)	2 (9.1)	6 (11.8)
Recipients on Oahu who refused participation in the investigation	2 (6.9)	1 (4.5)	3 (5.9)
Total living renal transplant recipients	29 (100)	22 (100)	51 (100)

Note. Numbers in parentheses indicate percentages.

^a Two related transplants underwent transplant surgery in California.

TABLE 6.—Age at Initial Hemodialysis, First Transplant, and Transplant Waiting Period of the Interview Group

	RELATED TRANSPLANTS	CADAVERIC TRANSPLANTS	<i>t</i> -TEST	DEGREES OF FREEDOM	PROBABILITY
Mean age (years) at initial hemodialysis ^a	27.3 (10.7)	33.3 (15.0)	1.5	39	n.s.
Mean age (years) at first transplant ^b	28.3 (10.8)	34.8 (14.8)	1.6	39	n.s.
Mean length (months) of transplant wait ^c	12.5 (9.7)	17.9 (14.6)	1.4	38	n.s.

Note. Numbers in parentheses indicate standard deviations.

^{a,b} No data for one related transplant at hemodialysis and transplant ages.

^c No data for two related transplants for transplant wait.

TABLE 7.—Comparison of Age at Initial Hemodialysis, First Transplant and Transplant Waiting Period for the Total Renal Transplants Performed in Hawaii and the Interview Group

	TOTAL GROUP ^a	INTERVIEW GROUP ^b	t-TEST	DEGREES OF FREEDOM	PROBABILITY
RELATED TRANSPLANTS:					
Mean age (years) at initial hemodialysis	27.6 (10.3)	27.3 (10.7)	<1	51	n.s.
Mean age (years) at first transplant	28.6 (10.3)	28.3 (10.8)	<1	51	n.s.
Mean length (months) of transplant wait	11.7 (10.5)	12.5 (9.7)	<1	49	n.s.
CADAVERIC TRANSPLANTS:					
Mean age (years) at initial hemodialysis	34.4 (14.6)	33.3 (15.0)	<1	56	n.s.
Mean age (years) at first transplant	35.9 (14.8)	34.8 (14.8)	<1	56	n.s.
Mean length (months) of transplant wait	18.1 (13.7)	17.9 (14.6)	<1	56	n.s.

Note. Numbers in parentheses indicate standard deviations.

^aNo data for one related transplant for transplant wait.
^bNo data for one related transplant at hemodialysis and transplant ages and two related transplants for transplant wait.

ethnic groups represented in the sample were Chinese, Filipino, Portuguese, African and Spanish.

TABLE 8.—Ethnic Composition of the Interview Group

ETHNICITY	NUMBER	PERCENTAGE
Japanese	11	26.2
European	8	19.0
Chinese	3	7.1
Filipino	3	7.1
Portuguese	1	2.4
African	1	2.4
Spanish	1	2.4
Mixed ^a	14	33.3
Total	42	100

^aSubjects belonging to two or more ethnic groups.

As Table 9 indicates, most of the kidney recipients were either single or married, a small number being separated, divorced or widowed. Only four individuals reported a change in marital status after the transplant procedure, all from single to married. No change in marital status was reported after dialysis was initiated and only one report (divorce) was received for a shift in status after the renal problem was diagnosed.

TABLE 9.—Marital Status of the Interview Group

MARITAL STATUS	NUMBER	PERCENTAGE
Single	18	42.9
Married	17	40.5
Separated	3	7.1
Divorced	2	4.8
Widowed	2	4.8
Total	42	100

The divorced individual attributed the separation to problems present before the medical ones became apparent.

Cramond³ discussed the trauma upon a family when one of its members suffered from chronic renal failure and the illness and treatment

lingered over a long period of time. The more vulnerable homes and family members were observed to decompensate and became “ill” themselves. Both partners suffered under the stresses of the renal condition, and marriage dissolutions occurred, particularly in insecure marriage relationships, due to the inability of the healthy spouse to cope with the illness.^{3,7} However, the strength of the marriage and family relationships among the Hawaii renal recipients is indicated by the stability of these units over the course of the renal condition.

There were more men who were married or had been married (68.0% vs. 41.2% for women), while more women were single (58.5% vs. 32.0% for men). The younger mean age of the females at the time of the interview (33.5 years vs. 35.5 years for males) does not satisfactorily explain the sex difference in marital status. Women marry two years younger than men, on the average, and a larger percentage of women over men are married by 24 years of age.⁹ Within the interview group, the single women also tended to be older on the average (27.2 years) than the single men (22.2 years). The large number of single women may be explained by the social milieu imposed by the renal condition. Many of the single renal recipients were in their teens and early twenties when dialysis was initiated. This is also the period in life when heterosexual social activities which eventually led to mate selection occur. Patients whose lives were restricted and whose time was consumed by the dialysis treatments were generally not active socially. The recuperation from major surgery and the concerns with body image immediately following transplantation further reduced contacts between the renal recipients and members of the opposite sex. With increasing age, the male renal recipients had a higher probability of meeting prospective mates who would understand and accept their health status than did the female

renal recipients. The longer life expectancy for women in the general population produces a preponderance of women to men after the late teens, and the imbalance grows with age.² Thus, not only are there more adult women than men, but men have somewhat more control over their heterosexual contacts as they generally assume the overt “initiator” role in such relationships. The marital status of the female renal recipients was further affected by considerations, perceived by the patients or others, regarding the effect the renal condition might have on child-bearing and the expectancy of life to fulfill the child-rearing task.

TABLE 10.—*Living Arrangements of the Interview Group*

LIVING ARRANGEMENTS	NUMBER	PERCENTAGE
Living with immediate family (spouse, parents, or children)	37	88.1
Living alone	4	9.5
Living with friends	1	2.4
Total	42	100

As Table 10 indicates, 88.1% of the interview group lived with their immediate families, either with their spouse, parents and siblings, or children. The remainder lived alone or with friends. Although there were disadvantages to family living, family members were also the major source of support for many patients. The burdens of a kidney patient can be staggering. The medical costs of the treatment, the sessions on dialysis, and the psychological and emotional trauma of numerous medical procedures, including major surgery, were more easily borne if shared. In discussing the “coping behavior” of patients under extreme stress, Visotsky et al¹³ reported one of the key factors in recovery to be the relationship between the patient and family members in the re-establishment of self, return of self-esteem, and the adjustment to illness. McKegney¹⁰ reported strong associations between the continued presence of parental figures and the ability of patients to establish and maintain nuclear families and longer survival on

dialysis. Foster et al⁵ reported almost twice the percentage of survivors on dialysis had established and maintained nuclear families compared to non-survivors. Furthermore, suicide attempts had been 6 times more frequent among the decedants than among the survivors. Three members of the deceased group who attempted suicide had lost both parents and two of the patients were recently separated from their spouses. The impact of physiological and psychiatric factors on patients’ well-being is well recognized in medical practice. However, the contributions of patients’ environmental and social milieu in impeding or assisting the course of recovery are not as often appreciated.

Although marital status was not affected by the kidney problem, the employment status of this group (Table 11) changed dramatically over the three periods: a) before the renal problem occurred; b) during dialysis; and c) after transplantation. When the group of employed patients (i.e., full- or part-time workers or students) were compared with the unemployed group before the onset of the renal condition and during dialysis, the McNemar test for the significance of changes indicated employment status changed significantly for the interview group ($X^2 = p < .05$). The McNemar test indicated employment status was altered even more when the period before the renal condition was compared with the post-transplantation period ($X^2 = p < .01$). As patients moved through the three periods, they were less likely to be enrolled as full-time students or to be fully employed. Only half the patients who were full-time employees or students before the onset of their kidney problem were still in those categories after the transplant operation. The drop in the student ranks was expected. Moving through the three renal periods required time which allowed students to complete their education. Part-time employment reached a peak during the dialysis period because individuals who were fully employed initially reduced their working hours to accommodate the dialysis sessions into their schedules and for reasons of poor health, fatigue, and other related medical factors.

TABLE 11.—*Employment Status of the Interview Group During the Periods of the Renal Condition*

EMPLOYMENT STATUS	BEFORE THE RENAL PROBLEM	DURING DIALYSIS	AFTER TRANSPLANTATION
Full-time employment	24 (57.1)	14 (33.3)	13 (30.9)
Part-time employment	1 (2.4)	6 (14.3)	4 (9.5)
Student	15 (35.7)	12 (28.6)	8 (19.0)
Unemployed or non-student	2 (4.8)	10 (23.8)	17 (40.5)
Total	42 (100)	42 (100)	42 (100)

Note. Numbers in parentheses indicate percentages.

The unemployed non-student category swelled from 4.8% before the kidney problem period to 40.5% after transplantation. Two patients who were part-time employees after transplantation (one partly employed since dialysis) and two individuals who were unemployed since dialysis reported they were "retired." However, at the time of the interviews all of the aforementioned patients were younger than 65 years—the most commonly accepted retirement age in the United States—and the oldest patient was 56.9 years at the time of transplantation. Therefore, age alone was not responsible for the separation from full-time employment. Rather, the change in employment status was probably precipitated by health problems. Meeting the minimum criteria for years of service in some cases made early retirement feasible, although not necessarily the favorite choice, had circumstances been different.

Abram¹ discussed the bind between dependency and independency in which dialysis patients were placed. Transplanted renal patients may find themselves in a similar bind. Dependency characteristics which made for good adjustment during prolonged periods before transplantation may not be as useful post-transplantation, but patients may find it difficult to change behavior. Periodic bouts with graft rejection and physical impairment induced by the medication may interfere with the cultivation of independence and in locating employment. At the same time, the expectations of significant people and of the patients themselves, may be nothing short of full independence and return to pre-renal condition functioning. For example, Cramond's patients were rated "excellent" in recovery when they returned to their previous occupations after their transplants.³ Perhaps the assumption that full-time employment is a necessary condition for satisfactory recovery and rehabilitation should be re-examined. Such expectations impose additional psychological burdens on patients who find placement in full-time positions difficult because of the tight job market, reluctance of employers to hire transplanted persons,

necessity to change career fields, and conflict of medical treatment schedules with work hours.

Summary

From August, 1969, through February, 1975, 77 renal transplants were performed in Hawaii on 70 individuals, 46 males and 24 females. Seven patients received second kidney grafts when their first transplants failed to function. Immediate family donors were used in 33 cases, while 44 transplants utilized cadaver organs. Renal transplantations were commonly performed on adults; the very young and the very old were seldom recipients. Cadaveric renal recipients were older than related renal recipients at initial hemodialysis and transplantation and had a longer transplant waiting period. Patients receiving related grafts enjoyed higher rates of survival and functioning transplants, while more cadaveric transplants died or returned to dialysis. Unrelated cadaveric kidneys constituted the largest donor pool, followed by organs from siblings, and mothers.

Interviews were conducted with 42 surviving renal recipients, 25 males and 17 females, whose mean age was 34.7 years. Only three eligible patients refused to be interviewed. Twenty-three patients received grafts from immediate family members, and 19 were cadaveric transplants. Almost all of the major ethnic groups in the islands were represented, but patients of mixed, European, or Japanese ancestries were dominant. Most of the patients were single or married and lived in family settings. Their marital status tended to remain stable from before the renal condition until after transplantation. Before their renal problems, most of the subjects were either fully employed or attending school. After transplantation, there was an increase in the unemployed and non-student ranks. Part-time employment reached a peak during dialysis.

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HISTORY REPEATS ITSELF.

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Courtesy to brokers.

Sonographic Evaluation of Non-parasitic Liver Cysts

DAVID H. SAKUDA, M.D., *Honolulu*

● *Seven cases of simple non-parasitic hepatic cysts studied by hepatic sonography are presented. Hepatic sonography is suggested in certain patients with focal defects on radiocolloid liver scans.*

Flagg¹ in 1967 reviewed the world's literature on solitary non-parasitic liver cysts and found about 350 cases reported. He concluded that "solitary non-parasitic liver cysts occur with sufficient rarity to merit the reporting of each case." A review of the more recent literature reveals at least 30 additional cases.^{2,3,4} Since for the most part simple hepatic cysts are asymptomatic, it is apparent that the reported incidence does not reflect the true incidence of non-parasitic liver cysts. Eliason and Smith⁵ reported 28 solitary cysts in 20,000 consecutive autopsies at Philadelphia General Hospital. This would appear to give a more accurate picture of the true incidence of non-parasitic liver cysts. In a recent 15 month period, 7 patients with non-parasitic liver cysts were studied by diagnostic ultrasound—further evidence that this is not a rare condition.

Case Reports

Case 1: A 69-year-old asymptomatic woman of Portuguese ancestry was referred for radiocolloid liver scan because of slightly elevated SGOT and alkaline phosphatase on a routine checkup for hypertension. Liver scan revealed a large defect of the right lobe. A scan two years previously had been negative. Extensive workup included arteriography which revealed an avascular liver mass. Hepatic sonography demonstrated a large

cystic mass. At surgery the mass was a simple cyst with evidence of old hemorrhage within it.

Case 2: A 77-year-old asymptomatic Japanese woman was noted to have an epigastric mass on routine examination. She was followed regularly by her physician, including hospitalization eight months earlier for the nephrotic syndrome. Radiocolloid liver scan reported absent activity of the left lobe indicating either extrinsic or intrinsic mass. A pancreatic mass was a consideration. Arteriography revealed an avascular mass. Hepatic sonography demonstrated a huge cyst involving the entire left lobe of the liver. A simple liver cyst containing clear fluid was uncovered at surgery.

Case 3: A 44-year-old Hawaiian-Chinese woman was evaluated for a palpable liver. She was asymptomatic and all laboratory tests were negative. Radiocolloid liver scan revealed a large defect in the right lobe which was cystic on sonography. Exploration showed a simple cyst containing clear fluid.

Case 4: A 61-year-old Japanese woman was evaluated as an out-patient because of a large liver detected on upper gastrointestinal series for mild peptic symptoms. Radiocolloid scan revealed a large right lobe defect which was cystic on ultrasound examination. Laboratory tests were negative. The benign clinical picture and sonogram (Fig. 1) were typical of a non-parasitic liver cyst and further workup or surgery was not felt necessary in this patient.

Case 5: An 80-year-old Japanese woman was hospitalized for a lumbar compression fracture. As there was no history of trauma, a metastatic workup was undertaken. A radiocolloid liver scan revealed a single large central defect. This was cystic on hepatic sonography (Fig. 2).

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Accepted for publication July, 1976.



FIG. 1

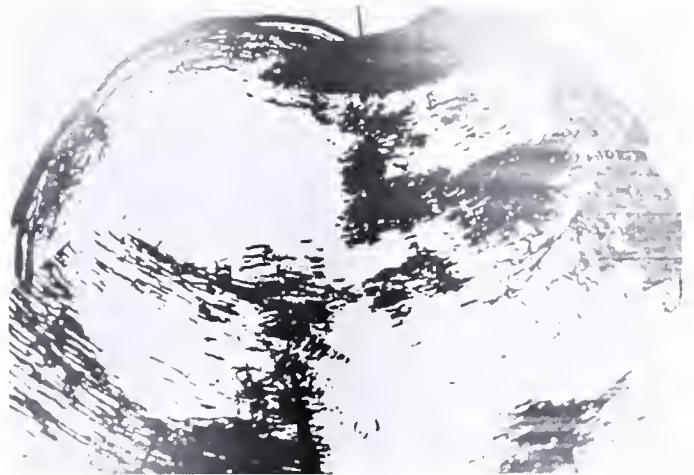


FIG. 2

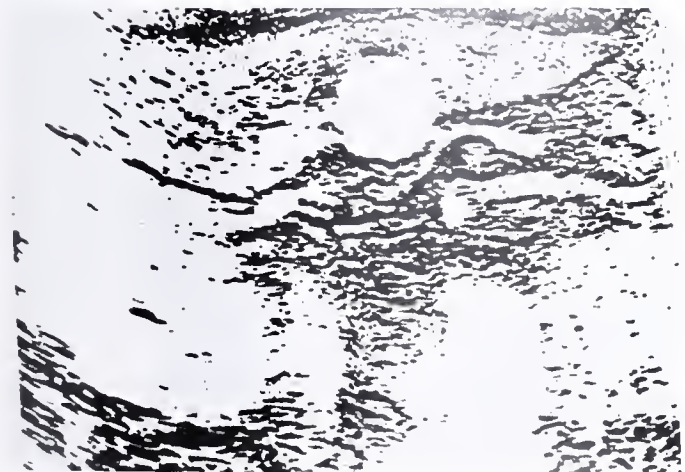


FIG. 3

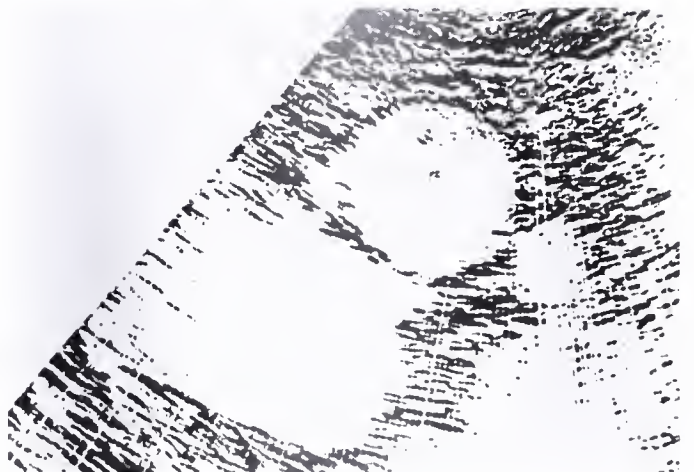


FIG. 4

Cross section hepatic sonograms. Patient's right side is at the reader's left. (V = vertebral body; A = aorta; C = cyst).

FIG. 1—(Case IV): Large cyst in posterior right lobe.

FIG. 2—(Case V): Large cyst in central liver.

FIG. 3—(Case VI): 4-5 cm. cyst in posterior left lobe. A vascular

structure just posterior to the cyst represents a normal splenic vein.

FIG. 4—(Case VII): Two adjacent cysts; one in left lobe and larger one in posterior right lobe. Note septum between cysts.

Further workup was entirely negative except for x-ray evidence of generalized osteoporosis. The clinical findings and sonogram were typical of a simple liver cyst and arteriography or surgery was not performed.

Case 6: An 80-year-old Chinese woman was noted to have a small palpable epigastric mass. Her complaint was "bloating" after meals. Laboratory tests, upper GI series, barium enema and IVP were negative. A radiocolloid liver scan was not done. Abdominal sonography was requested to rule out a pancreatic mass. Instead this revealed a 4-5 cm cyst of the left lobe (Fig. 3). This patient is also being followed without further diagnostic evaluation.

Case 7: A 49-year-old Japanese woman was admitted because of mild RUQ pain of two weeks duration. Four weeks prior to admission she slipped and fell but recalled no injury or pain. There was RUQ tenderness with a palpable liver. Pertinent laboratory data were minimally elevated SGOT and alkaline phosphatase, and Hgb 11.4. The radiocolloid scan reported a large solitary mass in the left lobe of the liver (Fig. 5). Gallium scan reported no activity within the

mass. Liver echogram reported two large adjacent cysts in the left lobe and posterior right lobe with an intervening septum (Fig. 4). Celiac arteriography revealed avascular defects corresponding to the scans without evidence of tumor vessels. Surgery revealed coffee-colored cyst fluid indicating previous hemorrhage into the cyst and evidence of chronic inflammation of the cyst wall. The two cysts were separated by a septum corresponding to the sonogram findings.

The hepatic sonograms of the surgically unproven cases (4, 5, 6,) are presented. The sonogram of Case 7 is also presented because of the demonstration of a septum.

Discussion

Pathology

Henson⁶ classifies liver cysts as follows:

1. Congenital
 - a. Solitary cysts
 - b. Polycystic disease
2. Traumatic
3. Inflammatory (specific, nonspecific)
4. Neoplastic (cystadenoma, dermoid, cystic teratoma)

FIG. 5—Anterior view of radiocolloid liver scan of Case VII. Large defect in left lobe extending to right lobe.



5. Parasitic

"Congenital" cysts are most commonly encountered. True neoplastic and post traumatic cysts are rare. Regarding the origin of polycystic livers, most writers favor the theory of congenital origin from retention of fluids in aberrant bile ducts. This same mechanism may apply in the pathogenesis of solitary liver cysts. The cyst wall may be thick or thin, depending on the amount of fibrous tissue. The lining epithelium is usually flat or cuboidal, similar to bile duct lining. Henson's series included cysts with various lining epithelia, including tall columnar, mucous producing, ciliated, and squamous cells (? epidermoid cysts).⁷ Presence of a proliferating epithelium distinguishes the simple from the neoplastic cyst.

Clinical Findings

While nonparasitic liver cysts have been reported from ages 4 days to 91 years, they are most common in the fifth and sixth decades and occur more frequently in females than males in the ratio of 5.3:1.¹ All seven patients reported here are women, five in the seventh and eighth decades of life.

Non-parasitic liver cysts are generally asymptomatic unless they have reached sufficient size to cause symptoms as a result of the space-occupying effect of the cyst. Thus they are usually large when diagnosed. Except for Case 7, all the patients reported here were asymptomatic from their cysts. In four cases, liver evaluation was prompted by a clinically enlarged liver.

Liver function studies were negative in all except two cases where the SGOT and alkaline phosphatase levels were slightly elevated. This is the usual picture, except when the bile ducts are compressed by the cysts with resultant jaundice.

Besides jaundice, other complications include infection, torsion of a pedunculated cyst, intraperitoneal rupture, and hemorrhage into the cyst.¹ Case 7 presented with pain and evidence of mild bleeding into the cyst.

Liver cysts are usually slow growing. Case 1 is

interesting in that radiocolloid liver scan was initially negative, then two years later revealed a large cyst. The cyst in Case 4 likewise probably grew rapidly considering the large epigastric mass was not discovered on hospitalization nine months earlier.

Malignant degeneration of hepatic cysts is extremely rare. There are four reported in the literature,^{4,8,9} two arising in polycystic livers. These patients were obviously symptomatic and were short lived.

Diagnosis

The radiocolloid liver scan is an established technique for detecting focal liver disease. However, it is relatively nonspecific as to whether a defect represents tumor, abscess, or cyst. Also extrinsic compression of the liver by adjacent organs may mimic intrahepatic disease on the liver scan. Fortunately in the majority of cases the clinical setting readily points to neoplasm or infection. The gallium citrate liver scan may be helpful in certain cases by the accumulation of gallium in various neoplasms and inflammatory conditions.

Hepatic arteriography may be extremely useful when tumor vascularity is demonstrated. A cyst or abscess can be indirectly diagnosed by revealing the avascular nature of the mass. Unfortunately avascular tumors may be confused with cystic masses on arteriography.

Hepatic sonography is unique in its ability to differentiate between solid and cystic masses with a high degree of accuracy.¹⁰ Sonography can also predict whether a cystic mass represents necrotic tumor or abscess versus simple cyst by the presence or absence of internal echoes.¹¹ Sonography in all seven cases presented here revealed echo-free cystic structures with smooth walls. A thin septum was clearly demonstrated in Case 7. Another advantage of ultrasound is the ability to represent cross-sectional anatomy and thus establish whether a radiocolloid scan defect is intrahepatic or extrahepatic. This is especially useful when evaluating the left lobe of the liver as in Case 2.

Prior to the use of hepatic sonography, the diagnosis of cystic liver masses could be confirmed only by exploratory laparotomy or needle aspiration. Now the combination of an echo-free or septated cystic mass and benign clinical situation should be sufficient to establish the diagnosis of simple non-parasitic liver cyst. The potential risks of arteriography and exploratory laparotomy may be avoided in these patients.

Summary

Seven cases of simple nonparasitic liver cysts were studied by hepatic sonography during a 15-month period. Four cases were proven surgically. All patients were women beyond age 40 and five were in the seventh and eighth decades. All patients were asymptomatic, except for one

who presented with pain secondary to bleeding into the cyst. Liver function tests were negative, except for mild abnormalities in two cases. Hepatic sonography revealed echo-free cystic masses in each instance. A thin septum was clearly demonstrated in one case.

Hepatic sonography is suggested in certain patients with focal defects on the radiocolloid liver scan when there is no clinical suggestion of neoplasm or infection. The finding of an echo-free

cystic mass in these patients is essentially diagnostic of nonparasitic liver cyst. The potential risks of arteriography and laparotomy may be avoided in these patients.

Acknowledgment

The author wishes to express his appreciation to Alice Marble, R.T. for assistance in performing the sonograms.

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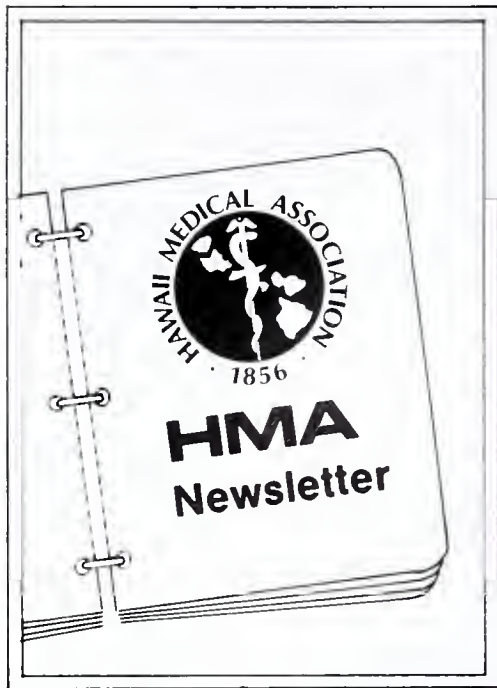
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JON WON

HMA Annual Meeting this year will be held in conjunction with an AMA Regional Continuing Medical Education Seminar at the Sheraton-Waikiki. All AMA CME courses must be registered for by individual physicians, including Hawaii physicians, on a **first-come, first-served basis**. So, if you plan to attend any AMA-accredited courses, please register early with the AMA. Call Bess Chang at HMA office for more details.

Honolulu County Medical Society plans a "grass roots" meeting of its physician members the evening of September 13, 1977, at the Ala Moana Americana Hotel in an effort to gather information from members regarding the future direction of the county society. The purpose of the meeting will be to examine the present county society goals and to attempt to get a feeling of the entire membership for setting county society program priorities. This will be an open forum with refreshments for those attending. County Society members and spouses are invited and welcome. More details in HCMS bulletins.

Congratulations to George H. Mills, M.D., elected to a three-year term as a member of the AMA Board of Trustees at the AMA Annual meeting in San Francisco in June. Dr. Mills has worked very hard for this election and because of this effort, the AMA and organized medicine will benefit!

A Most Pleasant Note has been received in the HMA office last week. A patient wrote in stating that it was a great pleasure to write a letter about how great her physician is. Her letter is short but has nothing but praise for her physician. She signs it—"a patient that really got well." I believe

this really can be written about physicians in general, for your patients, I would bet, feel the same way. Keep the faith!

Membership In The American Association of Medical Society Executives (AAMSE) now totals 576. These are executives in medical society, medical association, and specialty society organizations. It has grown in recent years and has been recently supported by funds from the AMA.

It Has Been Reported that a total of 588,065 persons were screened in state-supported diabetes detection programs during calendar/fiscal year 1976 and, as a result, 2,922 new diabetics were found—a yield of 0.5%.

Governor Brown of California is reported to have made a proposal to "open up" the medical profession by allowing nurses and medics to become physicians "through apprenticeship by working in hospitals or in doctors' offices and then taking whatever training is needed at night or through the community colleges or through the medical schools." Enough said?

The New Director of the Joint Commission on Accreditation of Hospitals (JCAH), Dr. John E. Affeldt, was named by the Board of Commissioners at its April 23, 1977 meeting in Chicago. Dr. Affeldt, the Medical Director of the Los Angeles County Department of Health Services, will assume the directorship on August 15, 1977, succeeding retiring Dr. John D. Porterfield who has directed the JCAH since 1965.

The Liaison Committee on Medical Education was granted recognition as the accrediting agency for medical schools for a two-year period by the U.S. Office of Education. The LCME's eligibility had been challenged this past spring by the Federal Trade Commission's Bureau of Competition on the grounds of potential conflict of interest.

Again it Must be Answered that the story about General Motors paying more for health insurance than for steel is simply not true, and it must be answered because Associated Press reports that this story was mentioned in a speech by the vice-president of the United States. General Motors has been trying to correct the story for four months that the GM bill for health insurance is larger than the bill it gets from U.S. Steel, but that GM buys steel from many companies and its total steel bill is much larger than its bill for health insurance.

"PSROs do not Exist as a library of health information for either the government or the general public," the AMA said in a statement to DHEW commenting on draft specifications for regulations on confidentiality. One proposed revision would permit PSROs to release data to state and federal licensing bodies or law enforcement agencies. Watch out, doctors. The heavy hand of Washington is coming closer.

Medical Office for lease. 1,625 sq. ft., seven exam, two consultation rooms; three years old. Suitable for two or three physicians. Available November, 1977. Contact Drs. Robert Clingan or Allan Izumi, Phone 521-6741.

Postgraduate Course, "Occupational Lung Disease," at Lakeview Country Club, Morgantown, West Virginia, Sept. 28-30, 1977. Sponsored by American College of Chest Physicians, West Virginia Univ. Medical School, and National Institute of Occupational Safety and Health. Meets criteria for 15½ hours Category 1 of Physicians' Recognition Award of AMA. Further information, direct correspondence to Dale E. Braddy, M.S., Director of Education, Amer. Coll. of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068.

Also Direct Correspondence to above contact for postgraduate course, "Clinical Spectrum of Critical Illness," at University of Tennessee at Nashville, Sept. 8-11, 1977. The American College of Chest Physicians certifies this continuing education program meets the criteria for credit in Category 1 of the Physicians' Recognition Award of the AMA.

Hawaii Receives AMPAC Leadership Award at the AMA Annual Meeting in June in San Francisco. Hawaii qualified for AMPAC's leadership recognition award and was one of nineteen states to receive this award during the opening of the AMA House of Delegates. The awards were given to states whose entire leadership delegation became 1977 Sustaining Members of AMPAC. Leadership delegations include state association presidents, presidents-elect, AMA delegates and alternate delegates, and the state's PAC chairman. Dr. George Mills, HMA delegate to the AMA, accepted the award for Hawaii. Dr. Mills formally presented the award to Dr. Leonard Howard, HAMPAC chairman, at the HMA Council meeting on July 8, 1977.



Trip Insurance

In Indiana, the word is that malpractice insurance premiums for Class I, II and III physicians has gone down 15%. Yes, down!

With the passage of Act 167-77 through the Ninth State Legislature in Hawaii, we have hopes of a similar reduction sometime in the future. As of now, however, Argonaut Insurance wants to increase premiums by 28%.

One of the large factors behind the astronomical rise in hospital charges has been the premiums hospitals must pay to protect themselves against suits. Therefore, a reduction in this one area alone can do much to alleviate the upward spiralling of room rates.

In relation to another subject (the swine flu program) but just as pertinent to our topic, six prominent medical scientists: Drs. Robert Ebert, John Enders and David Rutstein of Harvard Medical School, Dr. Thomas Chalmers of Mt. Sinai School of Medicine, Dr. Thomas Grayson of the University of Washington in Seattle, and Dr. Abraham Lilienfeld of Johns Hopkins, wrote to the *New York Times* (1/10/77) and said:

"The public must face the fact that there is no harmless or fool-proof medical procedure, including vaccination, a surgical operation, or the administration of a single aspirin or salt tablet. Every preventive or therapeutic measure is a trade-off between potential benefits and (adverse) side effects. Moreover, when the individual takes the chance to obtain a potential medical benefit after he has been properly informed of the benefits and the risks, he automatically shares responsibility with all those who provide and administer the agent."¹

This statement speaks to the essence of the dilemma in our society: the *base* for insurance against the liability is no longer broad enough. In our suit-conscious society, in a milieu of heavy emphasis on practicing law and relying on the courts to settle everything, insurance per se can

COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification
at His Home Without
Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony,
But Both Factions Are

WASHINGTON, Aug. 26, 1920—
struggle for wom-



Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,000,000
Persons When States Adopt Cooperating Laws—He Calls
the Measure 'Cornerstone' of His Economic Program

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10,
1971—The Senate approved
today 94 to 0 and sent to

WASHINGTON, Aug. 14
The Social Security Bill, providing
a broad program of unemployment
insurance and old age pensions
and counted upon to benefit
20,000,000 persons, became law
today when it was signed by Presi-
dent Roosevelt in the presence of
those chiefly responsible for drafting
it through Congress.

Mr. Roosevelt called the bill
"the cornerstone in a new social
security system which is being built
to meet the needs of a new
generation."

TRUMAN CLOSES

UNITED NATIONS CONFERENCE
WITH PLEA TO TRANSLATE
CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain

"If we fail to use it," he declared
to the solemn final meeting of the
delegates, "we shall betray all of
those who have died in order that
we might meet here in freedom and
safety to create it."

"If we seek to use it selfishly—for
the advantage of any one nation or
any small group of nations—we
shall be equally guilty of that be-
trayal."

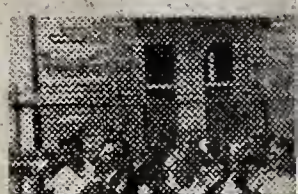
Fervent Interpolation

The President, speaking in the
auditorium of the War Memorial
Opera House, built in memory of
sons of the Golden Gate city who
gave their lives in the first World
War, in which he himself served,
seemed to give unconscious expres-
sion to the solemn feeling of the
occasion when, at the outset of his
speech, he interpolated the words,
half a hope, half a prayer:

"Oh, what a great day this can
be in history!"

the Draft Ends No

WASHINGTON, Jan. 27,
1973—"With the signing of
the peace agreement in
Paris today, and after re-
ceiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.



THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

no longer cover what can and may happen in the medical field. There are too many suits for alleged damages. There are too many awards in the range of the sky being the limit. There are too many out-of-court settlements even when no "wrong" can be proven, and the whole process of prosecution and defense, in cases of either right or wrong, has become too expensive for insurance carriers to finance at reasonable rates of premiums.

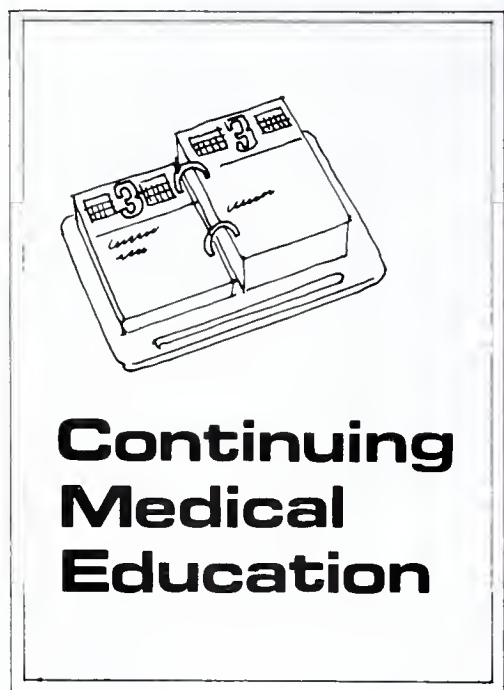
Therefore, the time has come to consider seriously "trip insurance." The place to start is in hospitals, where a large spin-off benefit might be the reduction in hospital costs, and as a consequence, in hospital charges.

If the above statement by these eminent medical men means anything, it is that the time has come for our patients to share the risks of modern diagnosis and treatment. It is no longer fair nor feasible for doctors and hospitals to carry the whole burden themselves.

We ask: Which will be the first hospital in our community to prevail upon insurance carriers to offer every patient admitted to a hospital a mal-occurrence, no-fault policy, the premium payment to be shared (based on actuarially sound figures) by patient, hospital and the attending (s)?

¹Harvard Medical School Health Letter Vol II No. 5 March/1977

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

(Contact CME Dept. for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m.
(Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professors' Program.

St. Francis Hospital

1. Medical Grand Rounds, Tuesday (4th & 5th) 12:30-1:30 p.m. Sull. IV Classroom
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
7. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Honolulu County Medical Society and Local Hospitals, Honolulu

Type: I, 1 hr/day, 1 day/mo from 12 mos

Fee: None Methods: AV, O, Pan

Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

Type: I, 1 hr/day, 1 day/mo for 8 mos

Fee: None Methods: AV, Clin C, O, Pan, R

Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

August 6, 1977 "Development of Cardiovascular Surgery," David C. Sabiston, M.D., Professor and Chairman, Dept. of Surgery, Duke University School of Medicine, Sat., 7:30 a.m., Kaiser Pac. Aud., 1 hr. Cat. 1, contact Kaiser CME.

Aug. 6-13, 1977 Ophthalmology—USC at Mauna Kea Beach Htl., Kamuela, HI. 1 week.

Aug. 8-21, 1977 Visiting prof. of Oncology, Am. Cancer Soc. HI Div. 200 N. Vineyard Blvd. Honolulu 96817. 10 days, 40 hrs. no fee. Ph. (808) 531-1662 for further info.

Aug. 11-22, 1977 20th Annual Postgraduate Refresher Course. Univ. of So. Calif., Schl. of Med. 2025 Zonal Ave., LA 90033. Held at Honolulu, Maui, Kauai, Kona. 37 hrs. Phil R. Manning, M.D. Assoc. Dean.

Aug. 13, 1977 "Psychiatric Services in a Prepaid Medical Care Setting," William J.T. Cody, M.D., Sat., 7:30 a.m., Kaiser Pac. Aud., 1 hr. Cat. 1, contact Kaiser CME.

Aug. 20, 1977 "Newer Developments in the Treatment of Peptic Ulcer," Myron Lezak, M.D., Sat., 7:30 a.m., Kaiser Pac. Aud., 1 hr. Cat. 1, contact: Kaiser CME.

Aug. 28-Sept. 3, 1977

Oct. 1-8, 1977

Oct. 6-9, 1977

Oct. 8-15, 1977

Oct. 8-16, 1977

Oct. 10-14, 1977

Oct. 15-22, 1977

Oct. 31, Nov. 4, 1977

Nov. 2-5, 1977

Nov. 12-14, 1977

Nov. 12-19, 1977

Nov. 26-30, 1977

Dec. 2-4, 1977

Dec. 5-9, 1977

World Psychiatric Association, Kathleen Bryan, Director, Meetings Management Dept., 1700 18th Street, NW, Washington, DC 20009. Hdq. Hotel: Sheraton Waikiki. Agent: Group Travel Unlimited.

Cardiology, USC at Mauna Kea Beach Htl., Kamuela, HI. 1 week.

Clinical Pharmacology, UCSF at Hilo, HI. Thurs.-Sat.

Endocrinology/Nephrology, USC at Mauna Kea Beach Htl., Kamuela, HI. 1 week.

Body Imaging Conf.-2nd Annual, West Park Hsp. Canoga Park. Held at Kauai Surf Htl., Kauai, HI. One week.

Practical Electrocardiography, Mem. Hsp. Med. Cntr. of Long Beach. Held at Hotel InterContinental, Maui, HI. Mon.-Fri.

Pediatrics for the Practitioner, Chldrn's Hsp. of Long Beach & Am. Academy of Ped.-Chapter 2. Held at Mauna Kea Beach Htl., Kamuela, HI. One week.

HMA Annual Mtg.-AMA Regional, Sheraton-Waikiki, Honolulu. Contact: Mrs. Bess Chang -HMA 320 Ward Ave. S 200, Honolulu 96814 or (808) 536-7702.

American Academy of Neurological Surgery, Dr. John Lowrey, 888 So. King St., Honolulu, HI 96813. Hdq. Hotel: Mauna Kea Beach. Agent: Not appointed.

Comprehensive Laparoscopy: Current Principles & Practice, UCSD at Kona Kai Club, Kona, HI. Sat.-Mon.

Workshops High Risk Pregnancy: Infertility, UCSF at Royal Lahaina Htl., Maui, HI. One week.

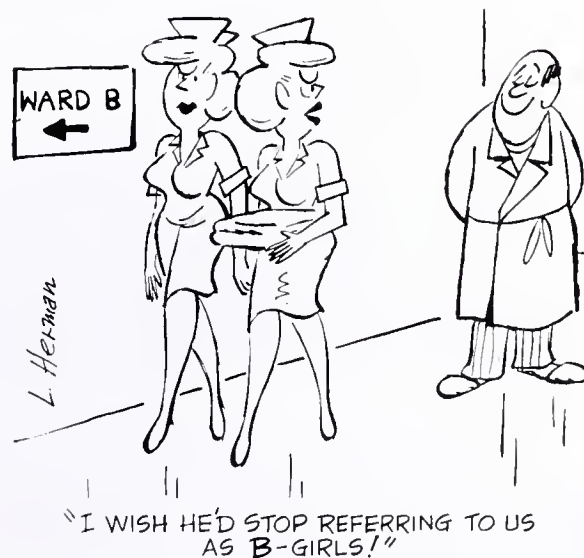
Lymphoproliferative Disorders, USC at Mauna Kea Beach Htl., Kamuela, HI. One week.

ENG Workshop, Pacific Med. Cnts., San. Fran. Martin Brotman, M.D., Chairman. CME, P.O. Box 7999, San. Fran. 94120. Held at Ilikai Htl., Honolulu. Fri.-Sat.

Cardiology Seminar, Hawaii Conference Services, P.O. Box 22670, Honolulu, HI 96822. Hdq. Hotel: Mauna Kea Beach. Agent: Group Travel Unlimited

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1976 Supplement to JAMA or call the HMA Office.



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Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

News of Members—Felix Lafferty has announced his candidacy to run for the AAFP Board of Directors, come elections in October at Las Vegas. Support from our members of the Hawaii Chapter will be of paramount value to his success. Please ask our ExecSec how you can help, either by writing to delegates from other states or by personal contact. So far, there are 4 other candidates announced from other state chapters. The *AAFP Reporter*, July issue, mistakenly credited **Don Farrell** with being the director of the 18-resident program in Family Practice at Tripler; pictured with the group and with visiting AAFP Pres. **Les Huffman Jr** is **Col. David Swanson**, the leader. Don is busy enough with the Kaiser residency program without taking on TAMC as well! **Larry Wong** finished up his stint as Chief-of-Staff at St. Francis hospital. **Howard Liljestrang** happily surprised everyone by coming to the 11 June dinner meeting at **Varian Sloan's**—he was only 1-month postop and one of many successful results of Mamiya surgery. Not only did Howard show off his sagittal scar, a la Lyndon Johnson, but he also related a harrowing tale preceding surgery, just after returning from a lengthy cruise voyage, and a nighttime emergency crisis. Lucky Howard had Richard at hand! **Kathleen Ackerman MD '77** from the UHSM is now a resident at Strong Memorial hospital in Rochester, N.Y. In our next issue, we will bring readers up to date on our other Student members who have graduated with their MD's lately.

11 June Dinner Meeting—Tom Walinski MD, orthoped, made the 22 members who were present much more aware of the potential problem of scoliosis in the schoolchild. His presentation seemed to interest and alert the wives and guests even more! Paul Cook, Administrator at Kapiolani Children's, spoke seriously of the hospital problem with high charges necessitated by high costs. 70% of hospital costs are labor-based; in most businesses, only 28% of their costs are due to labor. If the government imposes a 9% ceiling on what hospitals can charge in increases, as Congress threatens to do, the first item to be cut is "medical education" programs, i.e. the teaching part; next to go would be the expensive out-patient services, and thirdly the actual services to patients. He urged each physician to write to his Congressman and urge that such legislation be quashed.

AAFP Reporter—again the July issue, reports that in Indiana as of 1 May, malpractice insurance premiums for physicians in Class I, II and III were reduced by 15%. Here's hoping that the same will ensue in Hawaii. The Ninth State Legislature here did a good job with 1059 and we hope to see the results within a year. Every member should have received by now the AAFP's Eleven Ways to Minimize the Risk of Professional Liability Suits.

CME Reminders—AMA Cat 1 is NOT, repeat NOT, necessarily AAFP Cat "P"! The big one: USC-UH 13 to 24 August. AAFP in Las Vegas 10 to 13 October, followed by the Kona Invitational 13 to 20 October. Core Content Review starts 1 October and continues monthly times 6. All are P.

Book Reviews



Basic And Clinical Immunology

Doctor H.H. Fudenberg & Associates
Palo Alto, Lange Medical Publications, 1976. 653 pp.
Price, \$12.50.

This concise, but rather extensive publication on Basic and Clinical Immunology joins the many other publications of the Lange Company, to serve as a reference book for immunology in 1976. Basic sections in this volume, include (1) Fundamentals of Immunology; (2) Immunology and Cellular Immunology; (3) Immunobiology; (4) Immunologic Laboratory Tests available for evaluation of patients; (5) Immunological Aspects of Human Diseases in which immunological reactions play a major role.

Clinical chapters are particularly important in that each clinical entity discussed is generally preceded by major immunologic features for each disease. For example, under allergic rhinitis, the major immunologic features are clearly outlined: it is a common expression of atopic sensitivity, associated with a type I allergy, localized in the nasal mucous membrane and the conjunctiva; and that incriminating factors are pollens, molds, dusts, and animal danders. This type of format is followed in all of the various categories of diseases relating to and having immunological implications and involving each organ system.

The clinical discussions are excellent; however, specific therapy is not indicated, since this is not a manual on therapeutics.

There are 40 chapters in this book, each one well written, concise, and up to date. The chapter on immunization is particularly well done, and of special interest to clinical immunologists is a discussion of the experimental aspects of immunotherapy utilizing the new therapeutic techniques, both from the standpoint of bacterial stimulants and drug alteration of the immunologic mechanisms. A glossary of terms commonly used is complete, as is the section on acronyms and abbreviations commonly used in immunology.

I feel that this publication gives total coverage on the subject, and if a physician wants one excellent book for reference and information on basic clinical immunology, this would be an excellent addition.

GEORGE M. EWING, M.D.

Notes of a Feminist Therapist

Elizabeth Friar Williams, New York, Dell Publishing Company, 1976, 219 pp. Index. \$1.50

I had never heard of this book when I was asked to review it. It is not one of the "big books." Yet in an informal, personal style it has something valuable to say about women and psychotherapy.

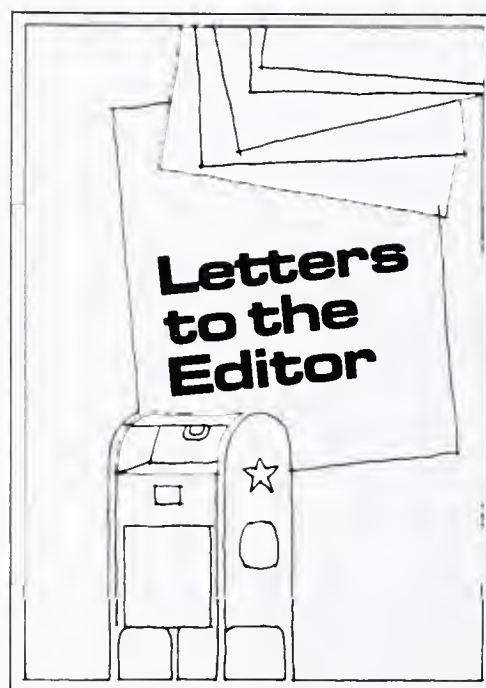
The word "feminist" is all too often linked to the stereotype of the tough, put-the-male-on-the-defensive "women's libber," however inaccurately this image may reflect the majority of women who strive to make a person's sex irrelevant in the political and economic arena, without feeling hostile or competitive with men on the personal level. Fundamentally, feminism stripped of this stereotype is simply humanism applied to women, and this comes through quite clearly in Williams' book. It is, to me, one of its major virtues. Another is an excellent description of common transference patterns and defenses in feminist-oriented therapy, which I have not seen described so well before and which I find very helpful to both women therapists and therapists of women.

Although I feel the author's illustrative case descriptions tend to be too pat, this is a minor criticism in view of the overall tone of balance and experienced truth that pervades her writing. She does not become polarized into a set viewpoint in order to avoid grappling with the paradoxes inherent in human experience. She delineates well several problems of today's woman which have not been studied or discussed at any depth, and have only begun to be articulated. One of these is the "fear of success" response, first demonstrated experimentally by Matina Horner, which leads women to unconscious self-sabotage when success,

particularly career success in a "man's world," seems just around the corner. Every therapist is familiar with the type of person gifted in "snatching defeat out of the jaws of victory." This pattern is by no means confined to women.

There are no real solutions to these problems in the book, but it would be unrealistic to expect any. Our society is in the beginning stages of a major transition in how people, women and men, define themselves and those who have stepped out of the traditional mold are like surfers on a wave who are trying to keep their balance. They are too busy coping with the now and creating new forms as they go along to objectively see the total pattern. The awareness that one is in the midst of a historical event does not afford a solid perspective for sound reflection. That comes later. In the meantime it is good to have some clarity about what is happening and the sharing of experiences by those who have had some practice in negotiating these particular "waves" of human history. I think Williams shares well.

HILLEVI KROON, PH.D.



To the Editor:

CHORIOCARCINOMA—"NATURE'S MALIGNANT TRANSPLANT"

Recently, we observed a teratogenic choriocarcinoma which originated within the anterior medias-

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tinum of a 27-year-old Japanese male. This highly malignant tumor is composed of trophoblastic cells which arise generally from gestational products and less frequently, in the gonads. In this case, the neoplasm arose in an extremely rare site, and is the only known example of extragenital choriocarcinoma in a male recorded in the Hawaiian medical literature.

In the patient, the tumor responded spectacularly to methotrexate, vincristine sulfate (Oncovin), and Actinomycin. However, he later succumbed to massive pulmonary and cerebral metastases twenty months after the tissue diagnosis. This length of survival is approximately twice that accomplished by other modes of chemotherapy.

This case contrasts immunologically with gestational choriocarcinoma in that only in the latter is there a subsiding of HL-A antibodies after several months of chemotherapy.

Apparently, the type of choriocarcinoma (extragenital) described here does not elicit an antibody reaction. This could be due to immunologic tolerance, blocking antibodies, or "molecular mimicry" to fetal or acquired antigens.

The most popular theory of the origin of teratomas is that primordial germinal tissue goes astray enroute to the primitive gonad.

Future treatment may well involve not only combination chemotherapy, as was used in this case, but also immunotherapy based upon exposure and/or production of the tumor's antigenic specificity.

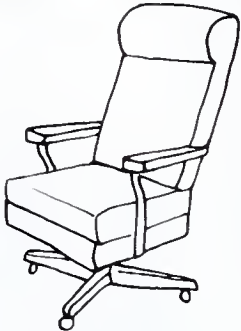
FOUNT K. HARTLEY, M.D.
St. Francis Hospital

ences in physical activity. Regular exercise causes lowering of the serum uric acid. Increases are seen in men who anticipate loss of employment and those who show greater ambition with achievement-oriented behavior.

The major cause of hyperuricemia is azotemia, in which uric acid values are about 10% of the BUN concentrations. Other common causes in hospitalized patients are acidosis, ingestion of diuretics, obesity, and arteriosclerotic or hypertensive cardiovascular disease. Serum uric acid usually rises following an acute myocardial infarct, but returns to the usual preinfarction range, which is often slightly higher than that of the normal population.

There has been considerable interest in racial differences. Studies in Hawaii have shown a high prevalence of hyperuricemia in the Hawaii Filipinos, although a later but smaller study found no difference between the Hawaii Filipinos and a multiracial group. An unpublished study at Kuakini Hospital showed significantly higher values in Hawaii Filipinos (590 cases) and Polynesians (556 cases). The Hawaii Caucasians showed mean values similar to those reported by Duff and co-workers in their Tecumseh, Michigan Study. The mean values for the Hawaii Japanese, Chinese, and Koreans were similar to those of the Caucasian group. Uric acid values tend to decrease in men and increase in women after the fifth decade, when the means for both sexes become approximately the same.

Serum uric acid levels are also affected by various drugs. Causes of increased levels include the antimetabolites, ascorbic acid, chloral hydrate, chlorothiazide, chlorpromazine, clofibrate, ethacrinic acid, furosemide, l-dopa, nicotinic acid, pipazinamide, low doses of salicylates, and spironolactone. Decreased levels may be due to adrenocorticosteroids, allopurinol, probenecid, dicumarol, marijuana, oxalate, high doses of salicylates, and sulfinpyrazone.



**Clinical
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FRANCIS FUKUNAGA, M.D.

SERUM URIC ACID

A single determination of serum uric acid may be misleading due to great individual variability. Serum uric acid concentrations are known to change under various physiologic and psychologic conditions. Normoactive subjects show significant diurnal and weekly variations. The levels tend to be higher in the midafternoon but there is no uniform hebdomadal pattern. The diurnal pattern is believed to be due to differ-

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From what our HMSA members tell us, more doctors seem to be perfecting that old fashioned 'bedside manner.'

To the patient, every illness is serious, especially surgery. Today more doctors are taking the time to explain what is going to be done, why it's being done and how much it's going to cost. Patients, too, seem to be more concerned and willing to talk

about these important matters.

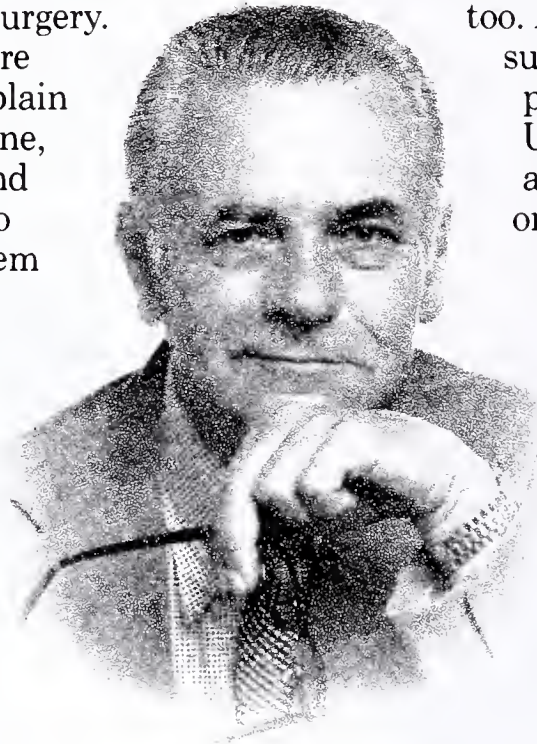
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AUGUST 1977
VOL. 36, NO. 8

Hawaii Medical Journal

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Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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HAWAII MEDICAL JOURNAL

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memo

31

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Wanted Movies of Ceremony,
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WASHINGTON, Aug. 26, 1920—
by struggle for wom-



TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain

"If we fail to use it," he declared
to the solemn final meeting of the
delegates, 'we shall betray all of
those who have died in order that
we might meet here in freedom and
safety to create it.'

"If we seek to use it selfishly—for
the advantage of any one nation or
any small group of nations—we
shall be equally guilty of that be-
trayal."

Fervent Interpolation

The President, speaking in the
auditorium of the War Memorial
Opera House, built in memory of
sons of the Golden Gate city who
gave their lives in the first World
War, in which he himself served,
seemed to give unconscious expres-
sion to the solemn feeling of the
occasion when, at the outset of his
speech, he interpolated the words,
half a hope, half a prayer:

"Oh, what a great day this can
be in history!"
Just before the plenary session

Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,000,000
Persons When States Adopt Cooperating Laws—He
the Measure 'Cornerstone' of His Economic Program

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10,
1971—The Senate approved

WASHINGTON, Aug. 11—
The Social Security Bill, p
a broad program of unemp
insurance and old age p
and counted upon to bene
20,000,000 persons, became
day when it was signed b
dent Roosevelt in the pre
those chiefly responsible
ting it through Congress.

Mr. Roosevelt called the
"the cornerstone in a s
which is being b
ment's comple
ring to

the Draft Ends No

WASHINGTON, Jan. 27,
1973—"With the signing of
the peace agreement in
Paris today, and after re-
ceiving a report from the
Secretary of the Army that

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.



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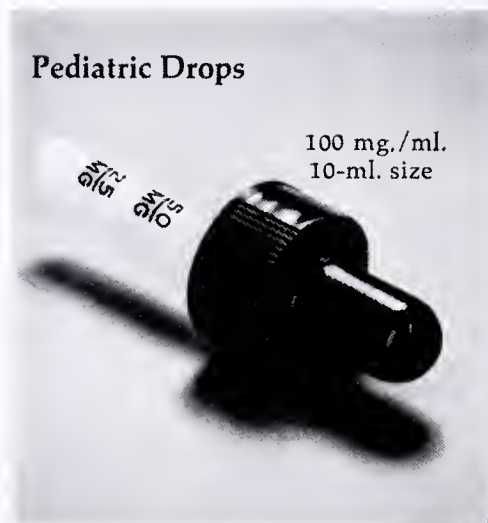
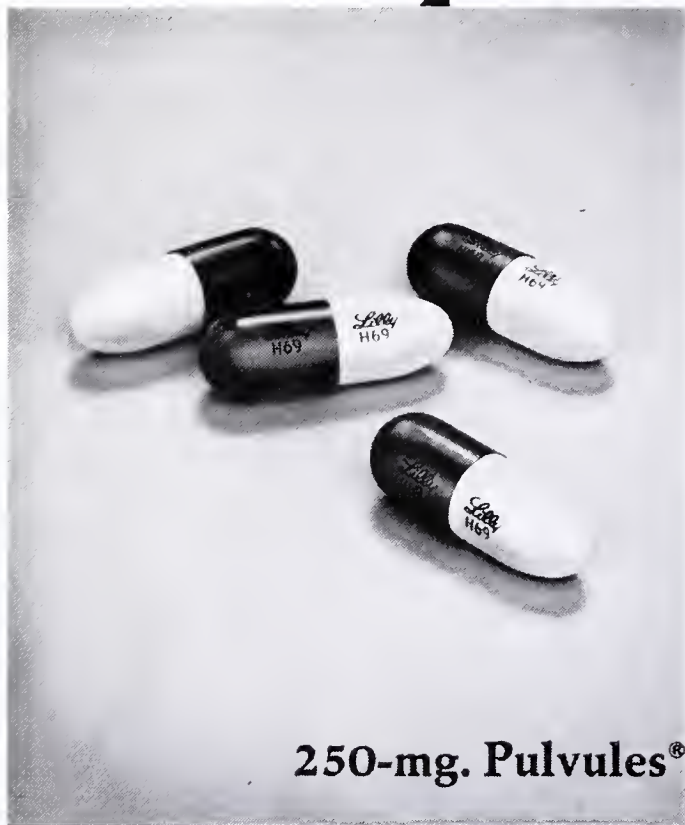
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Fish Poisoning in American Samoa

JOHN M. DAWSON, M.D., *Honolulu*

● *The first recorded outbreak of fish poisoning in the tropical Pacific occurred in 1606 as recorded by the Spanish explorer, Pedro de Quiros. In American Samoa, Jordan¹ made the first survey of poisonous fish in 1902, and several more recent articles on fish poisoning have referred to American Samoa as an endemic area for fish poisoning.^{2,3,4} In this present study, an average of 40 persons were hospitalized annually in American Samoa during 1970 through 1974 due to illnesses resulting from the ingestion of marine animals. Ciguatera accounted for more than one-third of these hospital admissions. Fish poisoning or "ichthyosarcotoxism" is an important economic and medical problem in American Samoa.*

Illnesses due to eating fish and other marine life can be related to poisoning by putrefied products, viral, bacterial, or protozoal pathogens, allergies, fish made toxic by chemical pollution of the marine environment, naturally toxic fish, or by toxins produced by microorganisms ingested by fish.⁵

Ciguatera is an example of the latter group, and ciguatera is the most important type of fish poisoning in the tropical Pacific. Ciguatera results from eating any of a wide variety of fish associated with coral reefs.^{4,6,7-10} A fish probably becomes ciguatoxic from a toxic microorganism in its food chain,¹¹ although the exact identity of the microorganism is not known.

Ciguatera is a symptom complex produced by eating fish containing ciguatoxin.^{12,13} Secondary toxins,¹⁴ the concentration of ciguatoxin in the fish, the amount eaten, and the individual's sensitivity account for the variability of the clinical syndrome.

Symptoms commonly begin several hours after ingestion, but may be almost immediate. Gastrointestinal disturbances of nausea, vomiting and diarrhea; neurosensory disturbances of

paresthesias and dysesthesias—sensation of burning or electrical discharge on contact with cold; arthralgias and myalgias; neuromuscular disturbances of paresis or fasciculations; and cardiovascular changes of hypotension and bradycardia occur singularly or as complexes.^{3,8,15} The toxicity of a specific species may differ according to the area or time; generally the larger specimens are more toxic than the smaller, and the viscera (liver, intestines, testes, ovaries) are more toxic than the flesh. Ciguatoxin is thermostable and a peculiar phenomenon of reduced tolerance occurs with repeated intoxications.¹⁰

Research Method

Data were reviewed retrospectively from inpatient records (1970-1974, inclusive) at the Lyndon Baines Johnson Tropical Medical Center, Pago Pago, American Samoa, of 198 admission cases related to the ingestion of marine animals, as determined by the admitting physician, discharging physician or medical librarian. We reviewed data prospectively, using standardized questionnaires,⁸ of 136 outpatients who presented themselves to the LBJ Tropical Medical Center, and the dispensaries on the islands of Ta'u, Fitiuta, Ofu (Manu'a group), and Swain's Island for illnesses related to the ingestion of marine animals during the period September, 1974 to September, 1975. Questionnaires were in both English and Samoan. Thirdly, we distributed questionnaires to Samoan medical officers and local fishermen, and conducted personal interviews with the Director of Marine Resources.

Results

Of the 198 inpatient charts reviewed, 33% were admissions for ciguatera; of the 136 outpatients surveyed, 43% had ciguatera poisoning (Table 1). Illnesses resulting from the consumption of fish were recorded as ciguatera only if the

TABLE 1.—Number of patients ill due to the ingestion of marine animals.

	INPATIENTS 1970 - 1974	OUTPATIENTS 09/74 - 08/75	TOTAL
Marine animals other than fish	64	33	97
Fish—other than ciguatera	69	44	113
Fish—ciguatera	65	59	124
Total	198	136	334

neurosensory symptoms of paresthesias or dysesthesias or the cardiovascular signs of hypotension and bradycardia (50/minute or less) were present. The category, "other than ciguatera," included food poisonings, scombroid poisonings and allergic reactions. Patients who presented with the symptoms of only vomiting, diarrhea, arthralgia, myalgia and/or weakness were included in the "other than ciguatera" group. However, some of these may have been cigua-

tera that were not clinically distinguishable from other poisonings.⁸

The 10 varieties of animals implicated in the illnesses resulting from eating marine animals other than fish are presented in Table 2. Reported in the ciguatera poisonings were 13 types of fish (Table 3). A higher incidence of ciguatera occurred during the period from October to December (Table 4).

TABLE 2.—Number of patients ill due to eating marine animals other than fish.

SAMOAN	COMMON	SCIENTIFIC	NO. OF CASES
se'a	sea cucumber	<i>Holothuria atra</i> (Cuverian organs)	25
palolo	marine sea worm	<i>Eunice viridis</i>	18
fe'e	octopus	several species	15
'ulatai	lobster	<i>Panulirus penicillatus</i>	11
pa'a	crab	several species	10
matamalu	sea anemone	<i>Rhodactis howesi</i>	5
tugane	clams	several species	2
'ula	shrimp, prawns	several species	2
vana	sea urchin	<i>Diadema paucispinum</i>	1
'ali'ao	top shell	<i>Trochus niloticus</i>	1
Total			90*

*Figure excludes 7 patients who had been included both as inpatients and outpatients.

TABLE 3.—Types of fish reported in the ciguatera cases.

SAMOAN	COMMON	SCIENTIFIC	CASES	%	PREVIOUSLY REPORTED BY:*
mu	red snapper	<i>Lutjanus bohar</i>	32	28	J; B; H
malie	shark	Carcharhinidae	22	19	
sapatu)		<i>Sphyræna obtusata</i>			
saosao**)	barracuda	<i>Sphyræna barracuda</i>	10	9	
pusi	eel	<i>Gymnothorax</i> spp.	5	4	J; B; H
ata ata	grouper	<i>Epinephelus merra</i>	4	3	J; B
gatala	grouper	Serranidae	3	3	
filoa	emperor	<i>Lethrinus</i> spp.	3	3	J
savani	snapper	<i>Lutjanus kasmira</i>	2	2	
lupo***)					
ulua)	jacks	<i>Caranx</i> spp.	2	2	
malai	snapper	<i>Lutjanus gibbus</i>	1	1	B; H
malau	squirrel fish	Holocentridae	1	1	B; H
not specified			29	25	
Total			114	100****	

Marine Resources¹⁶ reports additional fish producing ciguatera:

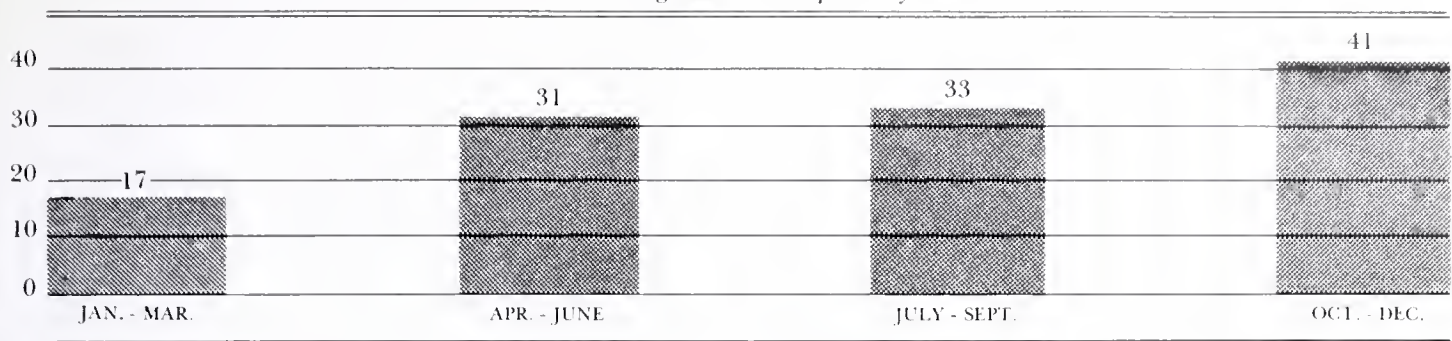
taiva	snapper	<i>Lutjanus monostigma</i>	"sometimes toxic"	J
pa'pa	grouper	<i>Variola louti</i>	1 case	

*Previously reported by: J-Jordan;¹ B-Banner and Helfrich;² H-Halstead.³

**Differentiation between these two species is not always made; sapatu was more commonly reported by patients, but saosao is generally considered more often poisonous.

***Lupo is the Samoan name for a jack under approximately one pound, and it is generally considered to be nontoxic.

****Total excludes 10 patients who had been included both as inpatients and as outpatients during the September-December 1974 period.

TABLE 4.—*Ciguatera* cases reported by month.

Chi square analysis comparing four groups:
 $\chi^2 = 9.80$ $df 3$ $p < .05$

Discussion

These data represent only those persons who, becoming ill after ingesting marine animals, attended a medical facility, either as outpatients or as inpatients. The director of Marine Resources estimates that no more than 10% of ciguatera poisonings reach the hospital or dispensaries.¹⁶ A house-to-house survey, as performed on other tropical islands,^{17,18} might yield more accurate data regarding the extent of fish poisoning in American Samoa.

Our inpatient figures necessarily rely on the accuracy and completeness of the admission records; the outpatient figures were collected with the assistance of the outpatient department staff. Therefore, the resulting numbers cannot be considered completely accurate. However, the outpatient department physicians and nurses reliably recorded the outpatient cases during the survey year.* Ciguatera resulted in 15 hospital admissions each year (1970-1974 average) and four times this number of ciguatera cases were seen as outpatients during the survey year. If the 10% approximation given by Marine Resources for the fraction of ciguateric illnesses seen at the hospital and dispensaries is accurate, then there is a ciguatera incidence of more than 20 per 1,000 ($100/10 \times 59/29$, $191 \times 1,000$) population in American Samoa.

Several serious cases with marked hypotension and bradycardia and one case of severe paresis were observed during 1974 and 1975. The usual course for the ciguateric syndrome in the territory is gastroenteritis for 1-2 days, weakness for 2-7 days, and paresthesias for 2 days to 3 weeks.** No fatalities were recorded due to fish poisoning during the study period (1970-1975). However, according to a previous report, 3 people died in 1958 with symptoms similar to ciguatera after consuming a green sea turtle (*Chelonia mydas*).²

The indicated seasonal variation of ciguatera is consistent with reports from Fiji where a peak is seen in October.^{19,20} Our study sample was biased in that only cases seen at the medical facilities were reported. Therefore, the hy-

pothesis that there is a seasonal variation in ciguatera or in ciguatotoxicity in the reef fish of American Samoa requires further testing.

Of the 13 types of fish listed as potentially toxic, 3 kinds accounted for more than 50% of the ciguateric cases: mu (red snapper)—*L. bohar*; malie (shark)—*Carcharhinida*; and sapatu and saosao (barracuda)—*Sphyræna* spp. The shark (elasmobranch) poisonings resulted only after the ingestion of the liver or gills, and these poisonings were commonly associated with the cardiovascular signs of bradycardia and hypotension. Gymnothorax (eel) and elasmobranch (shark) poisonings were included as ciguatera in this report in accordance with more recent publications.^{13,21}

The prevention of food poisonings and scombroid poisonings requires hygienic production and adequate storage and distribution. Other illnesses could be prevented if sensitive individuals avoided allergenic species and if marine gourmets adequately cooked sea anemones.²² However, the prevention of ciguatera is a difficult problem, since many of the common table fish (Table 3) of American Samoa are occasionally toxic.

The Department of Public Health has restricted the sale of mu (*L. bohar*); and the major fish market, on its own initiative, does not sell taiva (*L. monostigma*) or very large filoa (*Lethrinus* spp.). These 3 fish account for approximately 25% of the total bottom fish caught by the Samoan fishing fleet.¹⁶

Research efforts to find an inexpensive, efficient screening technique for ciguatotoxic fish is promising for the future,²³ but the only available screening techniques now are bioassay procedures, eg, with the mongoose¹⁰ which are too complex, inaccurate, and expensive for an endemic area such as American Samoa. Efforts to reduce the incidence of fish poisoning must rely on health education. Specifically, the following should be stressed for the prevention of ciguatera in American Samoa:

1. 13 fish have been implicated in ciguatera cases (see text for complete list), but 3 have produced more than 50% of cases: mu - red snapper; malie - shark (liver and gills) and sapatu and saosao - barracuda (Table 3).

*Personal observation and cross check with day books.

**Personal observation as outpatient physician, December 1973-August 1975.

2. Although a seasonal variation in ciguatera is indicated, no season is reliably safe (Table 4).
3. Most reef areas may yield toxic fish.¹⁶
4. The viscera of fish is more toxic than the flesh.^{10,21}
5. Larger fish are more toxic than smaller fish.^{10,25}
6. Cooking techniques have little effect on toxicity.²⁵
7. Common home tests in Samoa including the coin test (a silver coin cooked with the flesh of a toxic fish turns dark) and the fly test (a fly will not alight on a toxic fish) are experimentally invalid,²⁵ but prefeeding the viscera to a cat would be of benefit if the animal was observed closely for symptoms (lack of coordination, inability to stand) or regurgitation.²⁵
8. The early administration of an emetic is useful if vomiting has not already occurred.

Treatment Regimes

Although the ciguatera phenomena is not strictly comparable to anticholinesterase poisoning *in vivo*,²⁶ a confirmation test to aid in the diagnosis as suggested by Li²⁷ may still prove useful: an intramuscular adult dose of 1 mg. of atropine (a safe procedure²⁸) will fail to produce the expected signs of atropinization: dry mouth, lips and throat, dry skin, pupil dilatation, and tachycardia, if ciguatera poisoning is present.

The following pharmacologic agents have been experimentally or clinically tested in ciguatera poisoning:

1. Native Plants^{3,24,30}
2. Neostigmine and physostigmine^{25,31}
3. tubocurarine chloride³²
4. vitamins^{8,15,20,34}
5. EDTA (calcium disodium edetate)³⁴
6. cortisone^{8,25,34}
7. edrophonium²⁵
8. magnesium sulfate³²
9. methyl phenidate hydrochloride³²
10. procaine amide³³
11. oximes^{8,15,26,27,31,32,34}
12. atropine^{8,15,20,25-27,31,32,34}
13. calcium salts^{8,20,25,32,34,35}

The oximes, eg, protopam chloride^R (pyridine-2-aldoxime methchloride), have been extensively used by Bagnis;¹⁵ however, his results and the results of others^{32,34} would indicate that the oximes are effective and safe only during the early phases of the syndrome. Atropine has been

used in conjunction with other pharmacologic agents in many treatment regimes and is safe if administered after cyanosis has been corrected and if the dosage is adequately monitored (doses up to 33.6 mg. of atropine have been used during the acute stages.³²) Atropine has reliably given symptomatic relief from abdominal pains and, together with electrolyte infusions, is effective for the correction of hypotension and bradycardia.³⁴

Ciguatera toxin has been shown to have a widespread direct action on excitable membranes.^{36,37} Calcium has been shown to be a competitive inhibitor* of ciguatoxin on frog membrane.³⁸ Reports of the ineffectiveness of calcium infusions^{20,35} may be related to the small dosages of calcium utilized (eg, 10 ml. of calcium gluconate³⁵) considering the competitive type of interference suggested for ciguatoxin.

Respiratory therapy including ventilation support should be utilized in combating respiratory failure if it occurs. This is the common mechanism for ciguatera fatalities.^{26,31}

The general initial regime of intravenous electrolyte solution, vitamins and atropine at therapeutic dosages (0.4-1.0 mg. q 3-4 hours subcutaneously) together with additional symptomatic treatment was used in American Samoa during the period of this study (1970-1975) and no ciguatera related deaths occurred during this period. Until more data accumulate, the possible benefits of any therapeutic modality should be weighed carefully against the potential risks. The early administration of an oxime (Bagnis¹⁵) and high doses of atropine (Okiihiro³²) have received empirical validation; however, if the mechanism of ciguatoxism in man is consistent with the laboratory results of Rayner,³⁸ large infusions of calcium salt might prove to be the treatment of choice for life-threatening ciguatera if adequate clinical and biochemical monitoring is available.

Acknowledgements

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*Following Michaelis-Menten kinetics, except at low calcium and high ciguatoxin concentrations.

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JON WONG

Honolulu County Medical Society will conduct a self-assessment of the role and function of county medical societies within the structure of organized medicine. On September 13, 1977, at 7:00 p.m. at the Ala Moana Hotel, a special meeting of the HCMS, along with spouses, will be held to take some critical looks at the operations and activities of the Society. **All Physicians**, both members and non-members, are invited to attend! As the concerns of medicine become greater and more complex with each passing day, organized medicine needs to know how, or even if, it can function to the benefit of the medical profession and its patients. If you physicians have any gripe about **your** medical society, or if you have something positive to say about it, or if you have any ideas to improve the functioning of **your** medical society, your officers and leadership wants and needs to know! We hope you will find the time to assist the leadership. **PLEASE MAKE AN EFFORT TO BE THERE. YOU CAN HELP.**

An Important Reminder to HMA members—the AMA Regional CME Seminar, which will occur in conjunction with the HMA Annual Meeting, October 31 - November 4, 1977, at the Sheraton-Waikiki Hotel, will have many Category I accredited courses that will be open to **all physicians**. If you desire to sign up for any of these courses, please register as early as you can as the courses are on a first-come, first-served basis, and physicians from all over the country are invited to attend. Contact Bess Chang at HMA for details.

The HMA Council, at its last meeting, adopted a resolution which establishes, for the purpose of friendly relations and exchange of information of mutual interest, a sister relationship with the Hiroshima Prefecture Medical Association. A contingent of the HMA leadership, including the President, President-elect, Executive Director,

and other Council members, is expected to present this resolution to the Hiroshima Prefecture Medical Association sometime in November, 1977.

The AMA will conduct a physician's Practice Management Seminar in Hawaii. A two-day, 6 hour Practice Management Seminar is being offered to physicians through AMA's Regional Continuing Medical Education Program on Thursday and Friday, Nov. 3rd and 4th, from 7:30 a.m. to 10:30 a.m. each day. It is part of AMA's overall CME program being conducted in conjunction with HMA's Annual Meeting at the Sheraton-Waikiki. Category I credit is given for this course (0-17 PRACTICE MANAGEMENT SEMINAR). The course is designed to increase practice efficiency, covering latest management techniques, business office procedures, task analysis, billing, collections, filing and medical records; telephone control and appointment scheduling. Time is allowed for questions and answers. Class sizes are limited, so register early—by early September. Information and applications for course registration available from Bess Chang at HMA office.

The Hawaii Chapter of the American Association of Medical Assistants will hold its 6th Annual Seminar on Sunday, September 25, 1977, at the Ilikai Hotel. The AAMA has for many years been the most active and instrumental organization in providing for continuing education and upgrading of skills of physician's office personnel. Give them your support. Interested medical assistants are urged to call Sally Kegler at 944-6449 or, after 6:00 p.m. at 735-1568.

A new In-Hospital Indemnity Plan for HMA physicians, sponsored by the HMA on a group basis, is now available to all HMA physicians. The current major medical insurance plan will not be renewed effective October 1, 1977. No correlation of benefits will be included in the new plan. The new plan will provide up to \$100 per day while confined in a hospital up to a maximum of 365 days for any one covered accident or illness. The normal age limit for acceptance during this initial enrollment is extended from age 60 to age 65 if the application is made prior to October 1, 1977. Present participants in the current Major Hospital Program are eligible to apply for the new plan with no age limitation. An In-Hospital Indemnity Plan brochure was mailed to all HMA members on July 29, 1977. Contact Higuchi Insurance Agency, Inc. at 531-7091 for detailed information and assistance.

Seven More types of Health Workers have been declared eligible to participate in the U. S. Public Health Service National Health Service Corps Scholarship program, HEW announced. Public Health nurses, clinical nurse-midwives,

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A Special Meeting To Examine Our Goals

WHERE? *Ala Moana
Hotel, Hibiscus
Ballroom*

WHEN? *Tuesday,
September 13,
1977*

TIME? *7 p.m. to 9 p.m.*

**ORGANIZED BY: HCMS
Ad Hoc Planning
Committee**

nurse practitioners, public health nutritionists, medical social workers, speech pathologists, and audiologists are now eligible to receive a \$6,750 stipend for a 12-month period in return for service for at least two years in a medically-under-served area.

U. S. House-Senate conference committee has agreed upon a one-year extension of several health programs. Among the programs given the simple one-year extension of authority to exist through fiscal year 1978 are health planning, home health services, community mental health centers, maternal and child health services, community health services and family planning. Changes in these programs will be considered later this year.

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Danger Ahead: Rationing of Care

In medicine as in other purchases, the buyer gets what he pays for. There is no steak-house medicine at hash-house prices. Prices of care cannot be harshly cut without cutbacks in the quality or quantity of care.

Those hard-boiled truths are obvious to us physicians, who deal with costs as a day-to-day reality rather than a pliable abstraction. And in its somewhat devious way, the federal government seems to perceive those truths, too.

The government's cluster of programs and proposals for containing costs is made to look like



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pure benefit for the patient, without any actual loss on his part. What they generally boil down to, however, is rationing of care.

This was a central point—and a central danger—posed by Richard E. Palmer, M.D., in addressing the AMA's annual convention last June as its outgoing president. Doctor Palmer identified rationing of care as a common denominator of proposed restraints in so-called unnecessary surgery covered by public funds, HMOs, the Health Planning Act of 1974, the push for generic drugs, and the proposed "cap" on hospital charges as a prelude to the Administration's National Health Insurance proposal.

On the proposed ceiling on hospital charges, he asked:

"Is it not predictable that the most creative, resourceful, and conscientious hospitals would suffer most from such economic artifice? Or that in treating all hospitals alike, the cap would penalize those that are already efficient, as a Senate health expert was quoted?"

Apropos of hospitals, it also must be recognized that some are inefficient; that some communities have too many; and that some costs—the Number One health-care concern of the public—can be restrained without disastrous results to quality. The medical field—through such means as the AMA's Commission on the Cost of Medical Care—must do its practical best against the economics that encourage federal rationing of health services.

HMO's, Doctor Palmer noted, have been hailed on Capitol Hill as "a great piece of ammunition" against rising medical costs. But what about the amount of care? Recent studies indicate that average HMO physicians see their patients less often and give less service—including preventive care—than do average fee-for-service physicians.

Shrinkage of service also could be the upshot of any NHI program that would ape Britain's National Health Service, said Doctor Palmer. For it has happened there.

As he summed up: "No individual—and ours is a nation of individuals—wants his care to fall victim to cost-effective common denominators. No individual wants his own care to be rationed."

Physicians at the local level should get this point across—as the government sharpens its ax against necessary costs.

Benefits should be tailored to need.

We are a society of people with a disparity between levels of socio-economic status.

Although we can be characterized as an affluent society with a generally high standard of living (our "poor" are indeed wealthy if compared with the destitute elements in India, for example), we do have somewhere around ten percent of the population in the United States that is arbitrarily classified at or below the pov-

erty level. And, of course, we have a large segment of "middle class"—the people who manage to get along in reasonable comfort from day to day, who manage to have a home and some luxuries with the help of mortgages and installment plans, but who can be easily wiped out in the event of a catastrophe. The latter includes the loss of a job perhaps. It also includes medical catastrophes. A medical catastrophe can seriously affect the pocketbooks of the wealthy, but its impact on a blue-collar worker can be disastrous.

In this day and age of "super-medicine," it is becoming more and more common to have vein graft by-pass surgical treatment for coronary atherosclerotic disease—at a cost of \$20,000 to \$30,000 or more. If private insurance or Medicare can cover 80% of this cost (and this is ultimately charged to society in the way of premiums or taxes!) the 20% that must come out-of-pocket is still a hefty \$4,000 to \$6,000. These dollars are not usually included in a person's lifetime budget.

The American Medical Association's bills in Congress: S 218 and HR 1818 address the problem forthrightly. They seek to tailor the benefits of a National Health Insurance program according to the needs of the citizens of this country, and according to their ability to be self-supporting without suffering undue hardship in each instance, both in terms of preventive "health care" and in medical crises.

In a capitalistic, free-enterprise society such as ours (and even the socialist and communist societies of the world cannot get away from being partly capitalist), it is right and proper that each citizen carry on his own shoulders what burden he can and must. Our graduated income tax is based on this premise. And, although we have been going down the road of welfarestatism, which is just another word for socialism, there are many persons in positions of power who are attempting to apply the brakes to this.

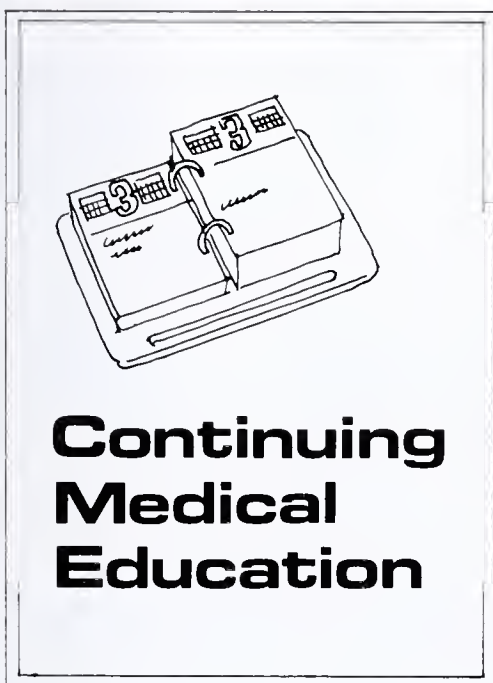
The major fault in Medicare is precisely this socialistic philosophy. Consider two patients in adjacent hospital beds who are receiving like treatment. If both are over 65 years old (Medicare beneficiaries), the retired, wealthy cutter-of-stock-coupons is charged the same as the retired carpenter, welder or farmer whose savings are nil. Although there is some justice to the principle that benefits from government should be distributed equally to citizens, we are not *that* affluent as a nation, that we can afford this sort of largesse to the rich. Witness the financial predicament of the Social Service Administration now, and as it is projected into a financially dismal future.

The AMA bills in Congress, aimed as an approach to counteracting the ever-looming horror of imposing an even costlier NHI scheme upon us all, are worthy of intensive study and then support by every member of organized

medicine. All other practitioners are likewise enjoined to walk with us and to spread the word to our patients: The people of the United States.

The AMA is asking the Hawaii Medical Ass'n to respond to its tactic. The HMA Council is responding on your behalf, but the final word rests with you, the medical, as well as with the general, electorate.

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1½ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

1. Endocrine Conf. every Wed. 1:00-2:00 p.m.
 2. Visiting Prof. Program-Sept. 19th, 1:00 p.m.
 3. Surgical Mortality & Morbidity-Sept. 23rd, 1:00 p.m.
 4. G.I. Conference-Sept. 27th, 8:00 a.m.
 5. Oncology Conf.-every Thurs. 7:30-8:30 a.m.
- (Contact CME Dept.-Kuakini for further info.)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
- Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
- Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
- Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
- Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
- Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
- Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
- Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
- Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
- Urology Grand Rounds, as designated
- Psychiatry CME Conference, as designated
- Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
 2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
 3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
 4. Radiology Conference, 4th Thursday, 11:00 a.m.
- (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat): not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professors' Program.

St. Francis Hospital

1. Medical Grand Rounds, Tuesday (4th & 5th) 12:30-1:30 p.m. Sull. IV Classroom
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
7. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—



America's

*

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" Effective: For controlling bronchospastic disorders. Final classification of the less than effective indication requires further investigation.

Contraindications: Because of the ephedrine, Marax is contraindicated in cardiovascular disease, hyperthyroidism, and hypertension. This drug is contraindicated in individuals who have shown hypersensitivity to the drug or its components. Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate to es-

tablish safety in early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy.

Precautions: Because of the ephedrine component this drug should be used with caution in elderly males or those with known prostatic hypertrophy.

The potentiating action of hydroxyzine, although mild, must be taken into consideration when the drug is used in conjunction with central nervous system depressants; and when other central nervous system depressants are administered concomitantly with hydroxyzine their dosage should be reduced.

Patients should be warned—because of the hydroxyzine component—of the possibility of drowsiness occurring and cautioned against driving a car or operating dangerous machinery while taking this drug.

Adverse Reactions: With large doses of ephedrine, excitation, tremulousness, insomnia, nervousness,

palpitation, tachycardia, precordial pain, cardiac arrhythmias, vertigo, dryness of the nose and throat, headache, sweating, and warmth may occur. Because ephedrine is a sympathomimetic agent some patients may develop vesical sphincter spasm and resultant urinary hesitation, and occasionally acute urinary retention. This should be borne in mind when administering preparations containing ephedrine to elderly males or those with known prostatic hypertrophy. At the recommended dose for Marax, a side effect occasionally reported is palpitation, and this can be controlled with dosage adjustment, additional amount of concurrently administered Atarax (hydroxyzine HCl) or discontinuation of the medication. When ephedrine is given three or more times daily patients may develop tolerance after several weeks of therapy. Theophylline when given on an empty stomach frequently causes gastric irritation accompanied by upper abdominal discomfort, nausea, and vomit-



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TABLETS: ephedrine sulfate, 25 mg; theophylline, 130 mg; and Atarax[®] (hydroxyzine HCl), 10 mg.

MARAX[®]-DF SYRUP, per 5 ml: ephedrine sulfate, 6.25 mg; theophylline, 32.50 mg; Atarax[®] (hydroxyzine HCl), 2.5 mg; and ethyl alcohol, 5% v/v.

for bronchospastic disorders*
dependable • economical • convenient

g. Administration of the medication after meals will serve to minimize this side effect. Theophylline may cause diuresis and cardiac stimulation. The amount of Atarax (hydroxyzine HCl) present in Marax has not resulted in disturbing side effects. When used alone specifically as a tranquilizer in the normal dosage range (25 to 50 mg three or four times a day), side effects are infrequent; even at these higher doses, no serious side effects have been reported and confirmed to date. Those which do occasionally occur when Atarax (hydroxyzine HCl) is used alone are drowsiness, xerostomia and, at extremely high doses, voluntary motor activity, unsteadiness of gait, neuromuscular weakness, all of which may be controlled by reduction of the dosage or discontinuation of the medication. With the relatively low dose of Atarax (hydroxyzine HCl) in Marax, these effects are not likely to occur. In addition, the ataractic action of Atarax (hydroxyzine HCl) may modify the cardiac

stimulatory action of ephedrine, and concurrently, increasing the amount of Atarax (hydroxyzine HCl) may control or abolish this undesirable effect of ephedrine.

Dosage: The dosage of Marax should be adjusted according to the severity of complaints, and the patient's individual toleration.

Tablets: In general, an adult dose of 1 tablet, 2 to 4 times daily, should be sufficient. Some patients are controlled adequately with 1/2 to 1 tablet at bedtime. The time interval between doses should not be shorter than four hours. The dosage for children over 5 years of age and for adults who are sensitive to ephedrine, is one-half the usual adult dose. Clinical experience to date has been confined to ages above 5 years.

Syrup: The dose for children over 5 years of age is 1 teaspoon (5 ml), 3 to 4 times daily. Dosage for children 2 to 5 years of age is 1/2 to 1 teaspoon

(2.5–5 ml), 3 to 4 times daily. Not recommended for children under 2 years of age.

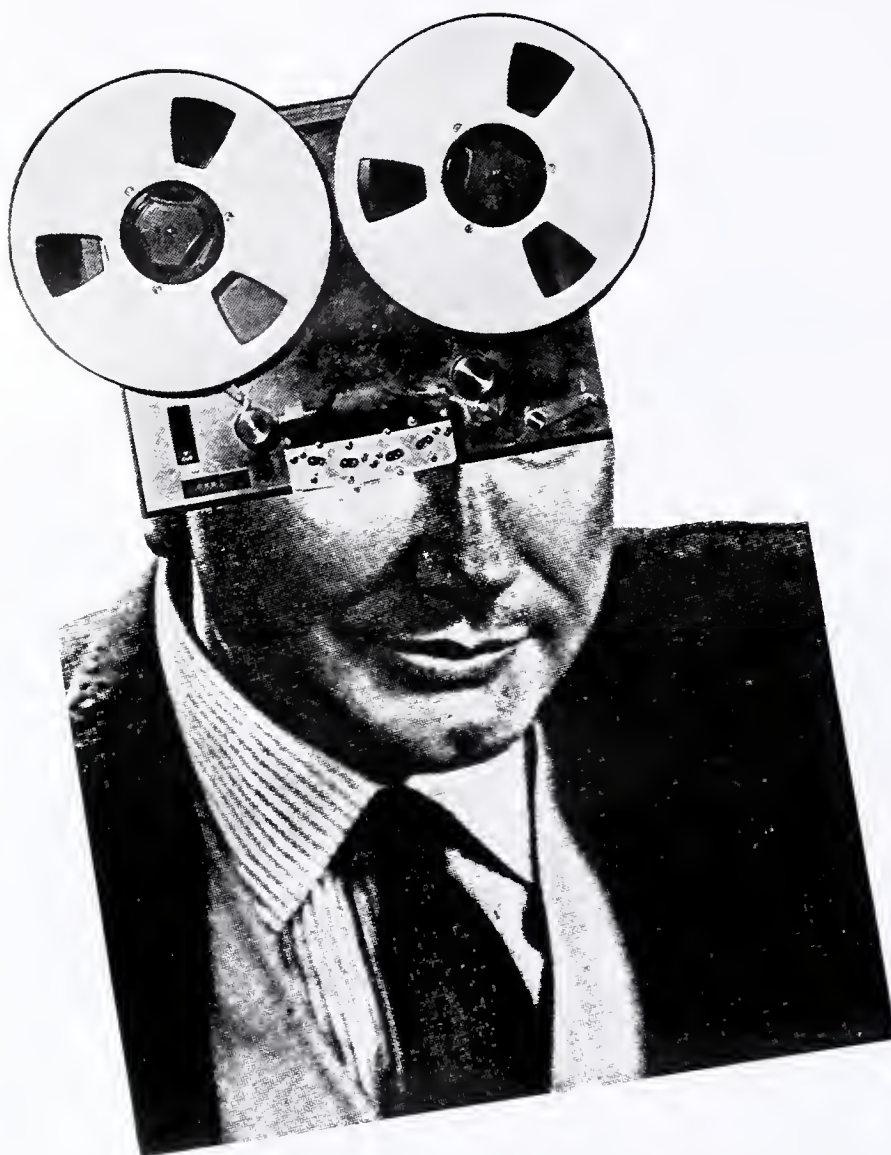
How Supplied: Marax Tablets are available as light blue, scored tablets in bottles of 100 and 500.

Marax-DF Syrup is available in pints as a colorless syrup free of all coal tar dyes, and should be dispensed in amber-colored bottles.

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last Wednesday

2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Honolulu County Medical Society and Local Hospitals, Honolulu

Type: I, 1 hr/day, 1 day/mo from 12 mos

Fee: None Methods: AV, O, Pan

Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

Type: I, 1 hr/day, 1 day/mo for 8 mos

Fee: None Methods: AV, Clin C, O, Pan, R

Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

Aug. 28-
Sept. 3,
1977 World Psychiatric Association, Kathleen Bryan, Director, Meetings Management Dept., 1700 18th Street, NW, Washington, DC 20009. Hdq. Hotel: Sheraton Waikiki. Agent: Group Travel Unlimited.

Sept. 10,
1977 "Kidney Function in Liver Disease"—Robert Morrison, M.D. Sat. 7:30 a.m., Kaiser Pac. Aud., 1 hr. Cat. 1. Contact: CME Dept., Kaiser.

Sept. 17,
1977 "Kaiser Annual Symposium"—(program to be announced) Sat. 11:30 a.m. 2 hrs. Cat. 1. Kaiser Pac. Aud. Contact: CME Dept., Kaiser.

Oct. 1-8,
1977 Cardiology, USC at Mauna Kea Beach Htl., Kamuela, HI. 1 week.

Oct. 6-9,
1977 Clinical Pharmacology, UCSF at Hilo, HI. Thurs.-Sat.

Oct. 8-15,
1977 Endocrinology/Nephrology, USC at Mauna Kea Beach Htl., Kamuela, HI. 1 week.

Oct. 8-16,
1977 Body Imaging Conf.-2nd Annual, West Park Hsp. Canoga Park. Held at Kauai Surf Htl., Kauai, HI. One week.

Oct. 10-14,
1977 Practical Electrocardiography, Mem. Hsp. Med. Cntr. of Long Beach. Held at Hotel InterContinental, Maui, HI. Mon.-Fri.

Oct. 15-22,
1977 Pediatrics for the Practitioner, Chldrn's Hsp. of Long Beach & Am. Academy of Ped.-Chapter 2. Held at Mauna Kea Beach Htl., Kamuela, HI. One week.

Oct. 31,
Nov. 4,
1977 HMA Annual Mtg.-AMA Regional. Sheraton-Waikiki, Honolulu, Contact: Mrs. Bess Chang -HMA 320 Ward Ave. S 200, Honolulu 96814 or (808) 536-7702.

Nov. 2-5,
1977 American Academy of Neurological Surgery, Dr. John Lowrey, 888 So. King St., Honolulu, HI 96813. Hdq. Hotel: Mauna Kea Beach. Agent: Not appointed.

Nov. 12-14,
1977 Comprehensive Laparoscopy: Current Principles & Practice, UCSD at Kona Kai Club, Kona, HI. Sat.-Mon.

Nov. 12-19,
1977 Workshops High Risk Pregnancy: Infertility, UCSF at Royal Lahaina Htl., Maui, HI. One week.

Nov. 26-30,
1977 Lymphoproliferative Disorders, USC at Mauna Kea Beach Htl., Kamuela, HI. One week.

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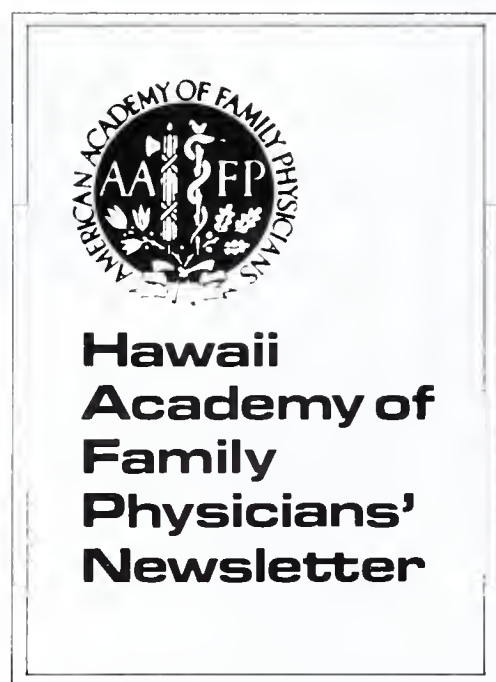
Honolulu: 521-1424 Maui: 244-0565 Hilo: 935-8946

For More Information Contact The Physicians Exchange: Adele Koch, 524-2575

- Dec. 2-4, 1977 ENG Workshop, Pacific Med. Cnts., San. Fran. Martin Brotman, M.D., Chairman. CME, P.O. Box 7999, San. Fran. 94120. Held at Ilikai Htl., Honolulu. Fri.-Sat.
- Dec. 5-9, 1977 Cardiology Seminar, Hawaii Conference Services, P.O. Box 22670, Honolulu, HI 96822. Hdq. Hotel: Mauna Kea Beach. Agent: Group Travel Unlimited

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1976 Supplement to JAMA or call the HMA Office.



J. I. FREDERICK REPPUN, M.D.

New Members—**Don Newman MD**, newly established on Molokai with Stevens and Langer is a new Active member. New Student members are **Peter Barnett**, UHSM '78, **Steven Orimoto**, UHSM '81, and **Howard Sakima**, UHSM '78. New Resident Affiliate member is **Joseph Wasielewski MD** in pathology at St. Francis Hospital. You are all welcome!

News of Members—**Garton Wall** is a member of the newly-formed Makiki Neighborhood Board. Hurrah for MD's getting into grass roots politics! **Fred Reppun** was re-elected chairman of the Kahalu'u NB. **Arch Wigle** of Naalehu is back in the AMA-HMA-HCMS fold and has been named Councillor from the Big Island to sit on the HMA Council. Arch's sagacity is much needed at that level. **Carlo Brizzolara** has moved and is practicing in Kona/Hawaii. **Pat Chinn MD '76** is in the Honolulu Surgical Integrated Residency Program. **Ben Diniega MD '76** has gone to Staten Island in New York to a Residency in Public Health. **Kerianne Garcia MD '77** is in Residency in Medicine at the UHSM. **Gwen Nishimura MD '77** is in the Flexible Program as a Resident currently in the FP program at Kaiser. **Fred Royce MD '77** has gone into the FP program as a Resident at the Regional Health Center in Amarillo, Texas. **Kevin Kunz '78** is on leave of absence from the UHSM in order to work in Senator Sparky Matsunaga's office in Washington, D.C. with the Subcommittee on Health. **Homer Izumi** plans to retire early in 1978 and wants to sell his office, fully equipped for family practice, in the Bank of Hawaii building at 1451 So. King St. The active practice goes with the deal, including introductions.

Congratulations!—to the second year class at the UH School of Medicine which, according to the UH Foundation letter, placed in the top 10% of all U.S. medical students in Part I of the National Board Exams. UHSM stands about No. 10 in the nation as a result.

AAFP Membership Division reports—that combining MD's and DO's, only Arizona and Iowa are states that reach a ratio of 40/100,000 population, which equals 1 family physician per 2,500 people. Hawaii has about 11/100,000 Academy members, but 25/100,000 family physicians. Minnesota Academy tops the list with about 96% of the State's family physicians enrolled in its chapter.

Australian Academy—of General Practice plans to have its meeting here in Honolulu 7-14 April 1978 and has invited HAAP and HMA to participate.

Dinner Meeting—tentative plans call for the next dinner meeting of HAAP on 17 September at **Tom Cahill's** in Aiea. Carl Weisbrod, M.A. in Psychology, with Psychiatric & Counselling Associates, will be one of the speakers and will discuss "Medical Hypnosis."

C.M.E.—AAFP Annual Scientific Assembly, 10 to 13 October is in Las Vegas this year, followed by the Kona Invitational 13 to 20 October. Third Annual Mardi Gras Supercourse on Lung Disease takes place in New Orleans 23-27 January 1978. All are "P" category.



Friday, February 4, 1977, 5:30 p.m.
HMA Meeting Room

CALL TO ORDER

The meeting was called to order by President Calvin C.J. Sia. Also present were Drs. William Dang, Douglas Bell II, Grover Batten, Marion Hanlon, Herbert Chinn, Ann Catts, William Kepler, Richard Lundborg, George Goto, J.I.F. Reppun, Leonard Howard, Rowlin Lichter, Sakae Uehara, Peter Kim, Verne Adams, Edgar Ho, Roy Kuboyama, William Moore, Paul Condit. Mr. Oren Chikamoto was also present.

MINUTES

The minutes of the meeting of January 14, 1977 were approved as circulated.

TREASURER'S REPORT

The December 1976 financial statement was reviewed in detail. Dr. Batten noted there a few minor adjustments that might need to be made as not all the information for the closing of the 1976 accounts had been received. The annual meeting income and expenses were reviewed and it was noted that expenses were higher than estimated for the speakers, banquet, and printing costs. Registration income was less than budgeted. The Capital Investment or Building Fund income and expenses were also reviewed. It was recommended that county medical society presidents be provided with a listing of their members who had not yet selected an option for the 1976 contribution to the Fund. Those who have not selected an option by March 31 will be considered delinquent and dropped from the membership rolls.

The Finance Committee had been referred the question of lowering the non-HMA member registration fee for the 1977 Annual Meeting. Mr. Won reported that he had spoken with Mr. Gayle Jewett from the AMA regarding this matter and that Mr. Jewett did not see any reason for HMA to change its policy regarding non-HMA member registration fees for the AMA's Regional CME Meeting which will be held in conjunction with HMA's meeting. The AMA's Council on CME will meet March 4 to further review this question. The Finance Committee recommends that the fee remain at \$50 for non-HMA members.

ACTION:

It was voted to approve the recommendation of the Finance Committee that the non-HMA member registration fee for the 1977 HMA Annual Meeting be \$50.

The Finance Committee also reviewed the fees for exhibitors at the annual meeting and recommends that the fee for exhibits be \$300/booth. The committee agreed that fee for scientific exhibits be limited to the set-up costs for the exhibit booth.

ACTION:

It was voted to approve the recommendation of the Finance Committee that the fee for exhibitors at the 1977 HMA Annual Meeting be \$300/booth.

COMMUNITY RESEARCH BUREAU

The HMA Council adjourned and the meeting of the Community Research Bureau was called to order by the secretary, Dr. O.D. Pinkerton. The Community Research Bureau was established to accept tax-free donations for education and scientific research and the members of the CRB are the members of the Council. The Trustees are the President of the HMA, the President-Elect, and the four living immediate past presidents, the president of each county medical society, and the elected officers of the CRB. The officers are elected by the members from nominees submitted by the Trustees. Nominations were offered as follows:

President—O. D. Pinkerton

Vice President—Herbert Y. H. Chinn

Secretary—Rowlin Lichter

Treasurer—Grover Batten

ACTION:

There were no further nominations from the floor. It was unanimously voted to elect the slate of officers presented.

It was suggested that the purpose of the Community Research Bureau be publicized to the entire membership.

HAWAII FOUNDATION FOR MEDICAL CARE

The Council is given the responsibility to elect the members of the Board of Trustees for the Hawaii Foundation for Medical Care. The HFMC has not met and it is recommended that the Council appoint the Trustees to fill the vacancies for Trustees George Mills, DeWitt Smith and Rodney West. The HFMC has been charged with the responsibility of looking into the feasibility of a statewide HMO and still maintains an insurance program for one union.

ACTION:

It was voted to appoint a nominating committee composed of Drs. Peter Kim, Sakae Uehara, Henry Yokoyama, Ann Catts, Winfred Y. Lee, and Henry Oyama. The committee will be asked to present their recommendations for nominees to the Board of Trustees for the Hawaii Foundation for Medical Care, keeping in mind that there should be a nominee from the county of Hawaii.

REPORT ON HMA INJUNCTION

Mr. Oren Chikamoto, speaking for Attorney V. Thomas Rice, presented a summary of Judge Arthur Fong's decision to deny HMA's motion for the issuance of a preliminary injunction against the State and the Board of Medical Examiners from taking action to revoke, suspend or limit the license of any doctor by reason of his failure to meet the financial responsibility provisions of Act 219. The alternatives for action were discussed in detail. Dr. Howard noted that the Act 219 Committee is seeking legislative relief for this provision of the law. It was also noted that the HMA has 45 days to appeal the decision and to study the various alternatives. It was agreed that the Council will continue to consider the number of options open to the HMA and will rely on the legislative process for justice. A letter to the HMA membership will be sent outlining the decision on HMA's injunction.

REPORTS OF COMMITTEES AND COMMISSIONS

A. Act 219 Committee: Dr. Leonard Howard briefly summarized the activities of the ad hoc committee which is seeking amendments to Act 219. He noted that several bills include many of the provisions the HMA is seeking. The Council gave a vote of thanks to Dr. Howard and the committee for their efforts.

B. Commission on Public Health: A proposal for school screening examinations for spinal deformities was circulated and reviewed. The School Health Committee recommends HMA support for this concept.

ACTION:

It was voted to support the School Health Committee's recommendation for support of the concept of a scoliosis screening program at Grade 6 in physical education classes in Hawaii's school system.

C. Mabel Smyth Board: Dr. Batten presented a progress report on the activities of the Mabel Smyth Board. He asked for Council recommendations re the use of the MSB lounge and lanai for office space.

ACTION:

The Council voted to refer this matter to the HMA Executive Committee for a report at the next Council meeting.

D. Medical Education: Dr. Edgar Ho reported that the Medical Education Committee is in the final stages

of getting together the CME recommendations to the Board of Medical Examiners. The recommendations at the present time are:

- (1) The AMA's Physician's Recognition Award or its equivalent as evidence of CME;
- (2) The HMA plans to set up a bookkeeping system to collect Category 1 credit information for physicians. This system is in the beginning stages and will need to be brought back to the Council for approval after the details have been worked out.
- (3) HMA plans a one-year award which will be based on one-third of the credits of the AMA's PRA Award.

E. Cancer Center Liaison: Dr. Condit reported that the ad hoc committee is continuing its review of the relationship between the Cancer Center and the University of Hawaii and the line of authority for the operation of the Cancer Center. The committee is also reviewing the relationship with the Hawaii Tumor Registry, the medical community and other areas.

F. EMS: Dr. Dang reviewed a pilot program begun by Hawaii County to send ambulance personnel to the mainland for training. The EMS Board is presently reviewing the curriculum and training standards for the State.

ACTION:

It was voted to appoint an EMS Advisory Committee to evaluate the training and standards of MICTs, EMTs, and report their findings to the EMS Board.

G. Self Insurance Committee: Dr. Sia reported that the committee is still pursuing a self-insurance program and is still investigating some of the questions raised at the last Council meeting.

H. DSSH: Dr. Sia reported that the executive committee had met with representatives of the Medicaid section of the DSSH. The committee discussed the recent news articles about the Medicaid program as well as Dr. Sia's response to the DSSH.

I. Building Committee: It was reported that there is a possibility of leasing additional office space in the building. The Building Committee is also reviewing the parking situation.

J. Reports of the County Medical Societies: Each county president briefly outlined some of the activities taking place in their respective societies. It is hoped that a report will be presented at each Council meeting.

NEW BUSINESS

A resolution was submitted for Council approval on the 3 on 2 program of the Department of Education.

There was some concern that the Council did not have sufficient background on the program upon which to base a decision. It was voted to table the resolution.

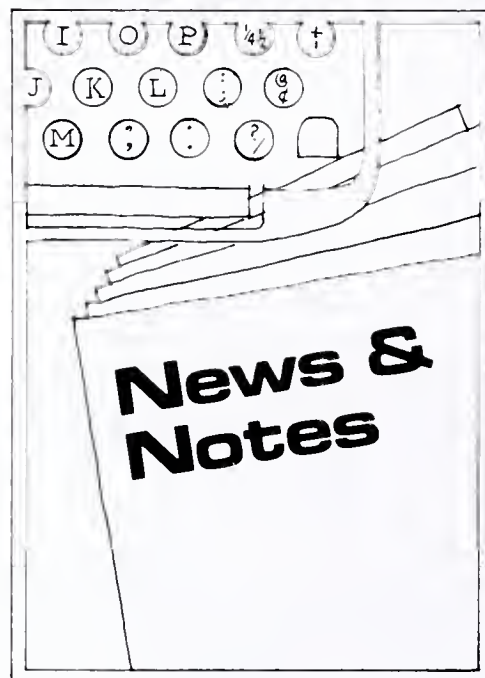
Mr. Won announced that he had received a call from the AMA Executive Vice President, Dr. James Sammons, who regretfully informed him that the HMA was eligible for only one delegate to the AMA in 1977.

ADJOURNMENT

The meeting adjourned at 9:45 p.m.

DOUGLAS B. BELL II, M.D.

Secretary



HENRY N. YOKOYAMA, M.D.

"Prescription for Eternal Youth"

by Leroy "Satchel" Paige

"Avoid fried foods, which angry up the blood . . .
If your stomach disputes you, lie down and pacify it with cool thoughts . . .
Keep the juices flowing by jangling gentle when you move . . .
Go very lightly on the vices, such as carrying on in society . . .
The society rumble ain't restful . . .
Avoid running at all times . . .
And don't look back . . .
Something might be gaining on you . . ."

(Gleaned from Convalescent Center administrator Stanley Snodgrass's news letter)



BLEMISHES?

COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

Lydia O'Leary
OF HAWAII

ALA MOANA CENTER—STREET LEVEL

PHONE 949-3288

Bulletins

The 121st Annual HMA Meeting is scheduled for Monday, Oct. 31st through Friday, Nov. 4th. The AMA's CME courses offered during the meeting require pre-registration via the AMA Department of Meeting Services, 535 North Dearborn St., Chicago, Ill. Offered are 22 Category 1 courses ranging from Basic Electrocardiography, Office Management of Sexual Dissatisfaction, etc., etc.

The Golf Tournament and Sportsman's Night will be on Monday, Oct. 31 at Mid-Pac CC . . . Skin diving tournament, Aug. 20-21 on Kalaupapa . . . Fishing tournament (Dates undetermined—contact **Andy Morgan**) . . . Ping Pong tournament (Contact **Joe Young**) . . . Tennis tournament (Contact **Worldster Lee** and **Dennis Maehara**) . . . Annual banquet, Friday, Nov. 4 . . .

Best bargain in town and open to all . . . Kuakini evening medical conference, 2nd Tuesday of each month at 6 pm . . . Drinks, excellent pupus and speaker . . . We attended the July meeting and partook of Vodka martinis and beer with spare ribs, broiled chicken, shrimp cocktail, salami, cold cuts, etc. Then listened to an excellent, relaxed talk by Terry Wong on Paget's Disease . . . CME credit to boot . . . Contact **Mel Kane-shiro**, Chief of Medicine, for details . . .

Professional Moves

The medical community is about to feel the dragon's long awaited fiery breath in this Year of the Dragon . . . In June, **Ben Leung** relocated to 169 A So. Kukui St.; ubiquitous urologist **Lee Simmons** has opened yet another office at the Kailua Medical Arts Bldg., 407 Uluniu St.; ENT man and head and neck plastic surgeon **Raymond Fodor** opened at the Wremco Professional Bldg., 602 Kailua Rd.; and "Drugless Practitioner" **Martin A. Hoffman Jr.** (who prevents disease by fasting, dietetics and patient education) relocated to Puck's Alley, 1019 University Ave.

In July, internist-gastroenterologist **John Morris** relocated to Suite 901 and OB Gyn man **Clayton Honbo** to Suite 1014 of the Queen's Physician Office Bldg. . . . Pediatrician **Jiro Saegusa** a/c the Pediatrics Associates Inc. at 1024 Piikoi St.; allergist **Robert Thune** a/c the Fronk Clinic; cardiologist **Ernest K.H. Lee** relocated to Suite 610 1441 Ala Moana; eye man **Harvey Minatoya** opened at 1003 Pensacola St. with fellow eye man and father; and otorhinolaryngologist **Roland F.S. Tam** joined the Pang Eye, Ear, Nose and Throat Clinic at 1374 Nuuanu Ave. On Kauai, pediatrician **Carlos J. Robles** joined the Kauai Medical Group Inc. and on the Big Island, **Charles Morin** a/c the Kohala Dispensary Ltd. . . .

From a Daacon column, we learned that popular cardiologist-joggers extraordinaire **Jack Scaff** and **John Wagner** have resigned from the Honolulu Medical Group and will go into private practice in January.

We are sorry to see 1976 Robbins Award winner **Livingston Wong** resign as head of the Emergency Medical Services Program which he had so assiduously upgraded into one of the nation's finest. Luckily, EMS has found a capable replacement in **Bill Dang** so all is not lost . . .

Life In These Parts

At the request 2 years ago of the Hawaii Nurses' Association, the State AG finally rendered the opinion that the physician, not the nurse, will decide whether or not an aborted fetus is alive. Apparently, intra-amniotic injections in second trimester abortions had raised this issue . . .

The County/State hospital system in Hawaii is proposing a 40% rate increase in hopes of beating Pres. Carter's proposed 9% increase limit for hospitals in 1977-78. Henry Thompson, deputy director of health, says the rate increase would generate 4 million dollars to offset the 8 to 9 million dollar cost increase for the 13 county/state hospitals . . .

Earlier, the Queen's Medical Center had increased its rates by 14% effective July 1. Semi-private rooms rose from \$81 and \$87 to \$98.50 and \$104.50; private room rates from \$99 to \$113.50 and CCU rates from \$275 to \$325 per day . . . (Heaven help the patient without hospital insurance . . .)

Much to our surprise, a State Department of Health survey revealed that except for tuberculosis and vision impairment,

immigrants to Hawaii are in better health than the residents . . . The total number of beds for chronic illness showed a rate of 707 days per 1,000 immigrants as compared to 1,607 days for in-migrants (from the mainland) and 1,750 days for residents . . .

Hawaii Tribune Herald scare tactics: "An estimated 4,067 Big Island residents have uncontrolled high blood pressure" . . . Based on a national survey, the writer has figured that 17.1% of the 21,366 Hawaii County residents should have uncontrolled pressures, while 3,785 people in the County should have blood pressures under adequate control . . .

"Kokua Na Keiki," a physical conditioning and health education program for children with asthma, will be initiated in Hilo by the American Lung Association of Hawaii. The program is an extension of a pilot program conducted in Honolulu by **Philip Foti** last summer.

The Family Planning Institute, which opened at Newtown Square near Pearl Ridge in Feb., is a private non-profit organization and one of a small chain of institutes located across the country. The parent organization SIGMA (Sexual Counseling, Infertility, Gonorrhea, Marital Counseling and Abortion) is located in Virginia. The Institute provides low cost individual and group counseling and offers a \$10 pelvic exam including a pap smear and an unhurried birth control conference . . . The staff includes **Lawrence Reich**, board certified OB Gyn man and a fleet of RN's and several rotating part time physicians.

Danelo Canete, president of Hawaii Heart Association, reported that 20% of the 7,000 Hawaii students with colds tested last year had strep, a figure 12% higher than anticipated.

Argonaut Insurance Co. which raised its premium rates an average 47% in September is negotiating with the State Regulatory Agencies for another rate increase of 30% effective July.

Hard working HMA legislative committee chairman **George Goto** was unhappy that several bills allowing family planning services for minors without parental consent died in the 1977 legislature. The present situation is that minors in Hawaii can have an abortion or be treated for VD without parental consent, but can't legally get birth control services. George points out, "This is particularly urgent because family planning services will help prevent the need for abortions." (A cart before the horse situation . . .)

The HMA is again getting complaints about a telephone caller who says he is a doctor conducting a survey on VD and pap smears . . .

On July 15, the 8-floor \$16-million Physicians' Office Building at Queen's Medical Center opened . . . The building will house 100 doctors' offices on 6 floors and a radiology section, laboratory, pharmacy and optical dispensary on 2 sublevel floors . . . Surgeon **Ben Tom**, one of its first tenants says, "The building set-up will reduce medical costs and improve the efficiency of patient care . . . The building is unique because the physicians who practice in it do so on an independent basis in contrast to Straub or Kaiser where the patient is obliged to use the facilities of the hospital or be treated by doctors assigned within the institution . . ."

An Oahu physician who wishes to remain anonymous and who has been practicing 20 years has been treating cancer patients with the controversial drug, Lactrile . . . He has found that the patients feel less discomfort from pain and agrees that the drug helps restore a vitamin deficiency . . .

Skin diver **Ed Dierdorff** has a shell collection stranger than most . . . The ENT doctor has a collection of shells he's found in patients' ears . . . "But that's not unusual," the Kailua doctor says. "Years ago when the song, 'Beans in My Ear' was popular, people were pouring in with beans in their noses and ears—that had sprouted!" (From Daacon—June 1)

Miscellany

Air Force 1 was headed for Russia with 5 passengers . . . President Carter, ex-Pres. Ford, ex-Secretary of State Kissinger, a priest and a hippie . . . The engines caught fire and the danger of crash was imminent . . . Alas, there were only 4 parachutes on board . . . Pres. Carter said, "I'm the most important man in the world . . . I better save myself." He

strapped on one of the chutes and jumped. Ex-Pres. Ford, "I'm still the next most important man so I'll take the 2nd chute . . ." Then ex-Secretary Kissinger stepped up, "I'm the smartest man in the world and the world cannot do without me." He grabbed a chute from the hippie, strapped it on and jumped . . . The priest told the hippie, "I've had a full and long life. You take the last chute and save yourself . . ." The hippie replied, "That's OK, Father . . . The world's smartest man just took my knapsack and went out the door . . ." (As told by Louise Tokumaru)

Personalities . . .

Personable **Ann Catts**, HCMS prexy, is popular and appreciated for the brevity of her board meetings. When asked how she manages such short meetings she replied, "Perhaps I just don't give anyone else a chance to say anything." Moreover, when she sees us at a meeting, she personally thanks us, "Good to see you here today . . ." How can we resist such charm and efficiency?

"Good Ol' Isle Boys Who Made Good In War And In Peace" **Ed Emura** and **Ed Yamada** were members of the VVV (Varsity Victory Volunteers) 35 years ago . . . After Pearl Harbor, the UH ROTC members were mobilized in the Hawaii Territorial Guards, but all the Nisei members including the two Ed's were discharged unceremoniously 6 weeks later . . . Rather than becoming disheartened (like some of us), they enlisted in the VVV (a work battalion for the Corps of Engineers) for another 11 months until the Army started taking Nisei for the 100th and the 442nd . . .

Bernie Fong's picture is on the front cover of a recent issue of the *Annals of Internal Medicine* . . . **Tom Leinweber** commented, "Bernie has replaced Jack Burns as Governor in these parts." But Bernie was more interested in telling a joke, re the Chinese technique for getting rid of unwanted hair . . . "What's the last sound one hears before the pubic hair hits the floor?" "Phfft!"

Doctors In Print

K.S. Tom, Consultant Feb. 1977 p. 121: "How To Manage Premature Rupture of the Fetal Membranes." K.S. says management depends on the length of pregnancy, the weight of the fetus . . . Induction of labor may be indicated, though watchful waiting is the treatment when gestation is 28 to 35 weeks . . .

George W. Starbuck, *Pediatric Annals*, March 1976: "The Recognition and Early Management of Child Abuse."

Six New Rules for Golfers

(From the *Sales Executive* Feb. Issue . . . And shown us by Tosh Tamura, a fellow golfer in misery)

"Here are some new rules for the golf course. They will help to reflect more accurately the true ability of players who could be pros if only they got an even break now and then: 1) A ball sliced or hooked into the rough shall be lifted and placed in the fairway at a point equal to the distance it carried into the rough. It is hardly fair to penalize the player for the erratic flight of the ball. 2) A ball hitting a tree shall be deemed not to have hit a tree. Hitting a tree is incontrovertably bad luck, a phenomenon which obviously has no place in a scientific game. The player shall estimate the distance the ball would have traveled under reasonable circumstances and play the ball from that point, preferably from a nice firm tuft of grass. 3) There shall be no such thing as a lost ball. The missing ball will eventually be found and pocketed by some other player, in which case it becomes a stolen ball. There is no penalty for a stolen ball. 4) If a putt passes over the hole without dropping in, it shall be deemed to have dropped. The law of gravity takes precedence over the law of golf. 5) A putt which stops close enough to the cup to inspire such comments as "You could blow it in" may be blown in. The rule does not apply if the ball is more than 3 inches from the hole. We have no wish to make a travesty of the game."

Hors De Combat

The Hawaii Nurses Association filed a suit in Circuit Court against the HMA and the Queen's Medical Center asking the court to enforce a 1939 agreement on maintenance of the Mabel Smyth Building . . . (Alas, have we come to parting of our ways with the HNA?)

We were perplexed by the following extracts from the NCAA's confidential report on U of H's violations of NCAA requirements: "Beginning in the 1971-72 academic year and continuing until the 1975-76 academic year, **Dr. Clarence Chang**, a representative of the University's athletic interests, provided cost free medical services to approximately 40 student-athletes at the University . . . In April 1971, prior to the departure of the University's inter-collegiate basketball team for a tour of Japan, Dr. Clarence Chang, a representative of the University's athletic interests, gave each member of the traveling squad Japanese Yen in amounts ranging from \$100 to \$175 to spend for his own personal reasons." (Since when does the providing of free medical services and monetary gifts to the needing constitute a crime?) We agree with Art Woolaway, president of the Koa Anuenue booster club who was prompted to remark, "If I'm guilty, the Aloha spirit is guilty!"

Dr. Kwanlin L.K. Wong, D.C., president of the Hawaii Chiropractic Association, wrote in "Forum": "Nearly everyone who walks into our offices asks, 'Are you covered by HMSA? . . . Unfortunately they must pay for our services as well as their HMSA premiums which do not cover chiropractic services . . . My advice to these deprived citizens is to write and call your insurance company, including the HMSA office and ask for chiropractic coverage, if it is not already included . . . If no action is taken, or a strong opposition is experienced, change your insurance company to one that will cover for a variety of things such as chiropractic, dentistry, optometry and podiatry . . ." (Ed: He certainly has the gall to lump chiropractors with dentists, optometrists and podiatrists . . .)

Sportsmen

Master tennis entrepreneur **Worldster Lee** arranged a match with the dentists for Thursday, May 26 at Leeward Community College . . . When several physician double teams, including the duo of **H. Yokoyama** and **Tommy Chang** did not show (Tommy had a primip start her labor that morning), Worldster and partner **K. Kern** played extra matches which they won. **Sam Wong**, the dental group chairman, maintained that the MD's had forfeited some games whereas Worldster insisted that the physicians had won. At the post tournament banquet at M's Ranch House, it was finally decided after some friendly repartee that the tournament will be a draw and that the perpetual trophy will be shared for the year . . .

The participating MD teams included the following:

McNamee-Shim; D. Andrew-R. Latta; V. Jobe-N. Scully; A. Roth-Huitt; W. Lee-K. Kern; J. Penoff-Hammon; H. Lawson-Budde; D. Maehara-T. Iwanuma; F. Lu-R. Mehta; N. Baysa-C. Loo; J. Popper-W. Tashima; W. Watt-C.M. Lum

On Starting A Practice of Surgery in Honolulu

John Lackadoo

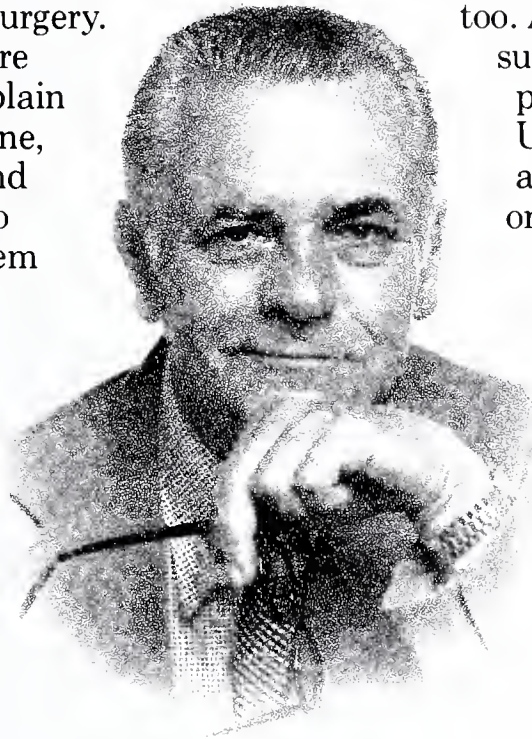
From revered chief resident to ignoble private surgeon trying to "break-in" in a large metropolis is a common plight each year for hundreds of young men. The following is a recounting of one's experience in Honolulu.

The city houses about 600,000 persons with little or no other "drawing" area in the vast Pacific. To service this pool are a veritable bevy of well-trained surgeons—most are "locals" but a good part are mainlanders enamoured of Hawaii. This dilution of physician to patient ratio poses a dilemma to the neophyte and brings us to the first of possible solutions.

The Gimmick. For example, Dr. Tarry Stuhl brought in the laser beam to excise hemorrhoids and got off to an explosive start; Tomago N. O. Atama, neurosurgeon, made it by im-

From what our HMSA members tell us, more doctors seem to be perfecting that old fashioned 'bedside manner.'

To the patient, every illness is serious, especially surgery. Today more doctors are taking the time to explain what is going to be done, why it's being done and how much it's going to cost. Patients, too, seem to be more concerned and willing to talk



about these important matters.

We think these are both healthy signs. We can all do our part to promote this kind of helpful dialogue.

We'd like to hear from you, too. Anytime you have a suggestion or question, please let us know.

Usually we can have an answer for you in a minute or two.

HMSA — the efficient way, for you and your patients.

Old Fashioned Dialogue is Back.

HMSA Utilization Review Department
Ph: 944-2355



planting cerebral bionic stimulators into Punahou under-achievers. So the "gimmick" does work, but it usually means an extra two to four years of training or the dog-lab. Let's explore the alternatives.

Ethnic. Hawaii is a melting pot of cultures, inter-racial mixing, etc., but "birds of same feather practice together" holds to some degree in this town. New Hiroshi Testiculato Chingstein fitted in *everywhere*, except in the O.R. where his brain was all Portagee.

Groups. Nice work if you can get it. The corporation gets relatively cheap labor and the young man keeps busy and pays his grocery bill. Once in, he may decide to climb the corporate ladder or bail out on his own with at least a mini-reputation in town. Appears ideal for the potential compulsive over-driving workaholic because it is virtually unheard of to be overly stressed there; in fact, at any conference, the Groupies can usually be discerned as the ones with the self-contented smiles and deep-bronze tans.

Relatives. A variant of *Ethnic*, but still applicable in a tradition-rich, in-bred community. Really a legacy for our children if they follow the footsteps—it behooves us, reputation-wise then, to quit pinching the nurses' okole, cute as it is.

Ultimate. If all else fails one can reach down into the depths of his soul and try to walk-on-water on any cases that come his way—and maybe, just maybe, after ten years or so, people might say, "Hey, this new kid has something to offer."

Joke Telling Contest Winners

(As recorded at the Annual Kuakini Staff Party)

"A Haole tourist watched a blind Buddha Head crossing a Hotel Street intersection with his seeing eye dog . . . The dog started across on the red light and the blind man was nearly killed by a car . . . The Haole was amazed to see the Buddha Head start to feed his dog pipikaula . . . 'You dumb bugga . . . (The tourist had learned local pidgin from his tourist guide book) How come you feed him pipikaula when he almost make you dead?' Came the indignant reply: 'You dumb Haole . . . I gotta know where his head is so I can kick him in the . . . ' (Beautifully told by **Dave Sakuda**)

"A 5'1 Jew figured he wanted to play at this private club . . . So he entered the pro shop run by a 6'3 white pro and asked, 'I'm Milton Greenstein . . . How's chances of playing golf here?' The anti-Semitic pro looked down at the lil' guy and declared, 'No way, brudda . . . This here is a private club . . . ' The lil' guy sez, 'I'll play you \$100 a hole and give you a stroke a hole . . . ' The pro took him on . . . The lil' guy shot sub par golf and after 18 holes, the pro was a \$1000 bucks down . . . The lil' guy sez sympathetically, 'I'll give you a chance to win back your money . . . Double or nothing that I can bite my right eye.' The pro figures a cinch bet and takes him on. The lil' Jew takes out his prosthetic right eye and bites it . . . 'You are now 2000 bucks down . . . Why don't I give you another chance at double or nothing? I'll bet you I can bite my left eye this time.' The pro sizes up the situation . . . He can't have two glass eyes since he played golf . . . So he took the bet . . . The lil' guy takes out his false teeth and carefully nips his good left eye . . . 'Well, how about another wager, double or nothing that I can pee over your head.' The pro thinks, 'I've already lost 4000 bucks . . . Things can't get worse . . . ' So he took the bet . . . 'But no more gimmicks, you understand?' So the lil' Jew takes out his ding-a-ling and starts to pee, but no matter how hard he tried, his pee could only reach the pro's face and no higher . . . Finally when his bladder was empty, he said resignedly, 'Well, that goes to show you can't win 'em all . . . ' (As told by our favorite gadabout neurosurgeon **Ralph Cloward**)

At the veterinarian's waiting room, two dog owners were discussing their pets' problems . . . One said, "My dog has heart worms . . ." The other remarked, "That's not so bad . . . My dog has syphilis . . . I didn't know you could get syphilis from fire hydrants." (As told by former Health Dept. director **Walter Quisenberry**)

A golfer was looking for his ball in the bushes when he heard someone in the bushes call, "Hey fellow, do you have

any tissue paper on you?" Bob replied, "Sorry, but I don't have any tissue paper," and continued to search for his errant ball . . . The voice called again with a note of desperation, "Say, you don't happen to have five singles for a \$5 bill?" (Another Quisenberry joke)

A woman was browsing through the pro shop looking for a gift for her husband . . . The friendly pro recommended a heavy putter with the comment: "You know what they say about putting, 'Never up, never in.' " The woman looked chagrined, "That's what the argument was all about . . . So now I have to get him a gift to appease him . . ." (Yet another Quisenberry gem . . .)

"A 747 jet was enroute to the Near East . . . A big Arab yelled at a lil' Jew, "Hey Jew, get me a cup of coffee . . ." The timid fellow obediently went to the rear and came back with a tasty cup of coffee . . . He noticed a fresh pile of dung on one of his shoes that he had left behind, but declined comment . . . Another huge Arab yelled, "Hey Jew, get me a cup of coffee too . . ." So he made another trip to the rear in stockinged feet and came back with another cup of coffee . . . He noticed another pile of shit on his other shoe . . . Enough is enough! The lil' Jew blurted, "This sure is a hell of a world . . . Arabs shitting on Jews' shoes and Jews pissing in Arabs' coffee . . ." (Another typical **Ralph Cloward** repertoire . . .)

Letters To The Editor

Editor, Hawaii Medical Journal 8 Feb '77
Dear Sir:

The arrival here of several consecutive issues of your journal without any lockerroom stories in the back pages gives me hope that this is not mere lack of material, but a change in editorial policy. I don't know if there are other regional or state medical journals which include such material, but of a hundred or so US medical journals which reach here one way or another, you had until recently the dubious distinction of being the only one to print regularly off-colour jokes.

I am no prude and accept such anecdotes in the right surroundings, but I must confess I have always felt they look very out of place in your otherwise elegant publication.

Yours faithfully,
H. de Glanville MD
Editor, Medicine Digest
P.O. Box 30125 Nairobi, Kenya

Dear Dr. H. de Glanville:
Sorry to disappoint you, but it was not exactly a change in editorial policy or a lack of material. This News Editor simply ran out of steam trying to meet deadlines. As you say, it is a dubious distinction, but dubious or not, it is a distinction. At least it appears that you have been reading the column which means the jokes have served their purpose. Thank you for the encouragement.

Yours sincerely,
H. Yokoyama, M.D.

Our "Angels"

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SEPTEMBER, 1977
VOL. 36, NO. 9

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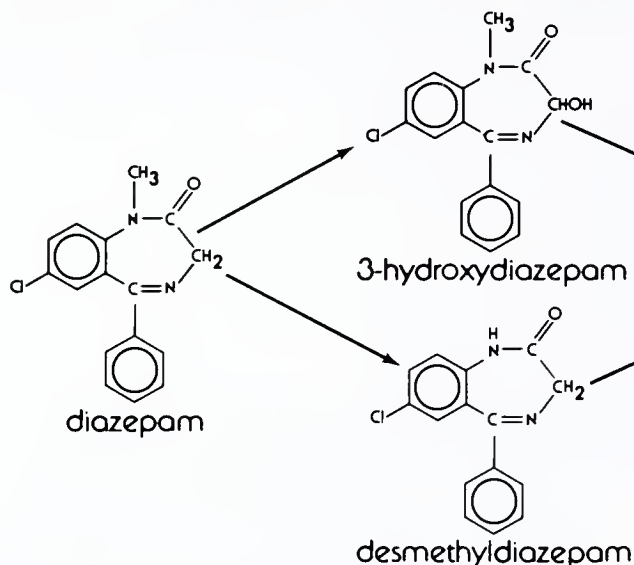
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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memo

31

**Monday
October
1977**

NO APPOINTMENTS
THROUGH NOV. 4

(Opportunity to
earn over 20 hrs.
of CME credits in
AMA Cat. I Postgrad
Courses. Attend the
Combined AMA Regional
Mtg. & HMA Annual
Mtg. at the
Sheraton-Waikiki)

A photograph of a woman from the chest up, shown in profile against a dark background. She has dark hair and is looking down. Her left hand, with dark red nail polish, is resting on her right shoulder. The skin on her shoulder and upper arm is covered in a severe allergic reaction, characterized by large, raised, red, and inflamed patches. The text "Allergic Dermatoses..." is overlaid in white on the lower right portion of the image.

Allergic Dermatoses...

Contraindications: Hypersensitivity to hydroxyzine. Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit, induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate to establish safety in early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as meperidine and barbiturates. In conjunctive use, dosage for these drugs should be reduced. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

Supply: Tablets, containing 10 mg, 25 mg, or 50 mg hydroxyzine hydrochloride, 100's and 500's; Tablets, containing 100 mg, 100's; Syrup, containing 10 mg per teaspoonful (5 ml) and ethyl alcohol 0.5% v/v, pint bottles.

Before prescribing or administering, see package circular.

with strong emotional overlay

the cause can be obscure

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WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,000,000
Persons When States Adopt Cooperating Laws—He Calls
the Measure 'Cornerstone' of His Economic Program

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to the House, the amendment to the Constitution that would require a minimum age of 18 for all voters in all elections.

WASHINGTON, Aug. 14, 1935—The Social Security Bill, providing for a broad program of unemployment insurance and old age pensions, became law today when it was signed by President Roosevelt in the presence of those chiefly responsible for getting it through Congress.

Mr. Roosevelt called the bill "the cornerstone in a new social security system which is being built, but which means complete freedom for the people."

TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, "we shall betray all of those who have died in order that we might meet here in freedom and safety to create it."

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

the Draft Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

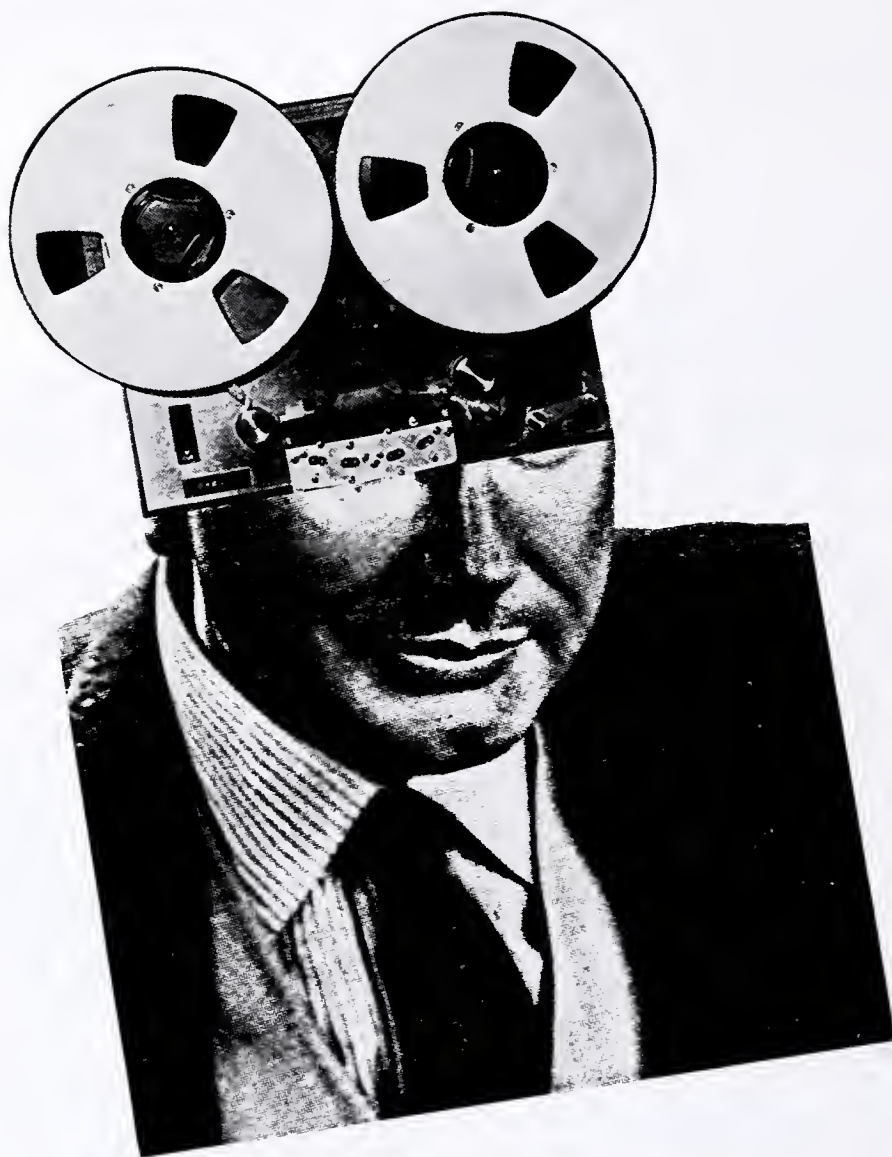
The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA

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The most frequently prescribed oral narcotic-containing combination.

Contraindications: Hypersensitivity to acetaminophen or codeine.

Warnings: Drug dependence. Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to other oral narcotics. Subject to the Federal Controlled Substances Act. Usage in ambulatory patients: Caution patients that codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery. Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) with this drug may exhibit additive CNS depression. When such a combination is contemplated, reduce the dose of one or both agents.

Usage in pregnancy: Safe use not established. Should not be used in pregnant women unless potential benefits outweigh possible hazards.

Precautions: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce

adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: Codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients: Administer with caution to certain patients such as the elderly or debilitated and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequent: lightheadedness, dizziness, sedation, nausea and vomiting, more prominent in ambulatory than nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Others: euphoria, dysphoria, constipation and pruritus.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For information on symptoms and treatment of overdosage, see full prescribing information.

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Guide Lines for the Physician Testifying Under the Amended Hawaii Mental Health Law of May, 1976

MELVIN BLAUSTEIN, M.D., *San Francisco*

● Governor George Ariyoshi signed Legislative Act 130 on May 20, 1976, amending the 1968 mental health law (chapter 334: Hawaii Revised Statutes relating to "Mental Health, Mental Illness, Drug Addiction and Alcoholism"). This fourth amendment of the law was made pursuant to the February 24, 1976, decision of the U.S. District Judge Samuel P. King in *Suzuki v. Quisenberry* declaring unconstitutional Sections 334-51, -53, -54, -71, and -73 and amending Sections 334-76, -81, and -86 as in violation of the due process clause of the Fourteenth Amendment. These sections are concerned with psychiatric admission procedures, transfer, leave and discharge, and appeal and review.

The current mental health act provides that, in emergencies, a police officer may take a person to a hospital if he or she is (a) committing an offense; (b) mentally ill or suffering from substance abuse; (c) appears to be imminently dangerous to property, self or others.

Criteria for involuntary hospitalization are defined: (a) that the person is mentally ill or suffering from substance abuse, and (b) that he is dangerous to himself or others or to property, and (c) that he is in need of care or treatment, and there is no suitable alternative available through existing facilities and programs which would be less restrictive than hospitalization.

"Dangerous to self" includes the concept of "neglect or refusal to take necessary care for one's own physical health and safety together with incompetence to determine whether treatment for mental illness or substance abuse is appropriate."

The amendment also states that emergency involuntary hospitalization may not exceed 48 hours without a judicial *ex parte* order. Should a

longer period of hospitalization be necessary, a court hearing will be held after notice is issued to interested parties. If the patient satisfies the criteria for involuntary hospitalization, he may be committed for up to 90 days unless discharged sooner. At the conclusion of the 90 day period, should the patient be in need of continued hospitalization, a rehearing is held.

The implementation of the current mental health law amendments with court hearings required for involuntary hospitalization may mean that many psychiatrists and other physicians unacquainted with the civil commitment procedures may be required to testify in court in order to ensure continued treatment for their mentally-ill patients. The author's concern is to familiarize the testifying physician with the proceedings and to present guide lines for preparation. The implications for psychotherapy, both positive and negative, of testifying to commit a patient are major issues; however, this paper will confine itself to the court process. The author's comments are drawn from personal experience as the forensic psychiatrist at the Hawaii State Hospital testifying in 33 cases during the first series of recertification hearings in September, 1976.

The hearings follow a standard format. First, the parties are identified. This will include counsel for patient (private or the public defender), counsel for the hospital (deputy attorney general), judge, court reporter, physician, witnesses and concerned parties. Documents, including the medication certificate, admission history, extracts from nursing and physician's notes and proof that notice was served to interested parties, are filed. If the patient is present (he may be excluded if too ill or too disruptive), his capacity to participate meaningfully is determined. At this point, the physician is sworn in, states name and address, and will testify as to the effect of the medication on the patient. If the medication is

found to be not too sedating and does not decrease the patient's capacity to participate, the medication certificate is accepted into evidence. After notice requirements are accepted, the Attorney General presents the case, calling on the physician, and frequently on the social worker and other witnesses. Public defender may cross-examine physician and witnesses and present additional witnesses. The judge then decides.

At the Hawaii State Hospital, the hearings are usually completed within an hour—obviously the complexity of the case will determine the time requirements. The hearings tend to be informal and the judge will allow the doctor to speak freely. The court appreciates the use of understandable terminology without medical jargon.

In preparing to testify in court for a civil commitment hearing, it is important to keep in mind the criteria that must be met for involuntary hospitalization. Reviewing the medical records and recent nursing notes, and interviewing the patient should be focused on substantiating grounds for continued hospitalization. Review of past records will usually give some indication of the possible length of hospitalization required, and past response to medication, as well as some chronological cohesiveness to the testimony.

The doctor is first asked to testify in regard to the patient's ability to participate meaningfully. On the morning of the hearings, the doctor will complete a standard medication certificate listing any sedating agents used within the past 24 hours. He will be asked in court to identify the "exhibit," name the medications and whether the medications "subdue or enhance" the patient's ability to participate. He may be asked about side effects, other medications administered, dosage and meaning of terms such as t.i.d., h.s., etc. Some patients may be receiving long-acting depot phenothiazines and some explanation to the court will be necessary. In none of the 33 cases at the Hawaii State Hospital was the medication found to be inappropriate or too sedating.

The case for the petitioner will be presented, and the doctor will be asked to testify as to the presence of mental illness or substance abuse, dangerousness to self, others or property, and need for care and treatment with no suitable alternatives. The doctor will be asked when he interviewed the patient and reviewed the medical records, and whether he has formed a diagnostic opinion as to the presence of mental illness or substance abuse. A "mentally ill person" by the new amendment "means a person having psychiatric disorder or other disease which substantially impairs his mental health and necessitates treatment or supervision." Both the organic brain syndrome and the functional disorders

meet these criteria. The doctor may also be asked about any medical problems and their treatment. He may be asked to explain the nature of the illness, terminology used and whether the condition is reversible, curable or treatable. The doctor may be asked to compare the patient's present condition to that on admission. In the case of the organic brain syndromes, a detailed differential diagnosis is not required. The physician may be asked whether the patient can speak, read, write, recognize people and understand events around him. In as much as the patient will usually be present in the court room, the communication difficulties of the organic brain syndromes will be readily apparent to the court.

The grounds for hospitalization are next developed, ie, dangerous to self, others or property. In the case of "dangerous to self," the concern is with suicidal behavior to neglect of one's physical health, and incompetence to determine whether treatment is needed. The physician will be asked about the patient's acts, attempts or threats to injure himself in the case of suicidal behavior. In other dangerous-to-self grounds for commitment, the doctor may be asked whether the patient has neglected to take necessary medication or food, whether he can care for his own physical health and safety, whether he can understand the need for treatment, and finally whether the patient is dangerous to himself. Many incontinent, (total care) demented organic brain syndrome patients and decompensated schizophrenic patients meet these criteria.

The issue of "dangerous to others" is more clear cut; ward nursing notes of aggressive behavior in the preceding 3 month period will be helpful. This category may include the organic brain syndrome patients who strike out or shout continuously and disrupt other patients. "Dangerous to property" did not form the basis for commitment in any of the 33 cases heard in September, 1976.

The doctor will then testify as to the need for care or treatment, indicating the treatment plan, future goals and the patient's expected response. The physician may be asked for reasons why the care and treatment at the present setting is "best" for the patient, or whether the patient could receive adequate care elsewhere. With the assistance of the social worker, testimony is given regarding alternative facilities.

In all the 33 cases in September, 1976, for involuntary commitment, the patients met the criteria of the new law and were committed for periods up to 90 days. In 2 cases, the judge set a 30 day period of hospitalization; in 2 other cases of senile total nursing care patients, alternative facilities existed but there were no openings.

The Primary Empty Sella Syndrome in Hawaii

CLYDE NAKAYAMA, M.D.*, WERNER G. SCHROFFNER, M.D. and
RAYMOND M. TANIGUCHI, M.D., *Honolulu*

• *Most doctors tend to equate an enlarged sella turcica on a skull film with an expanding tumor of the pituitary or adjacent structures. Occasionally, however, the enlarged sella is not filled with tumor but with spinal fluid, which is displaced by air on pneumoencephalography, thereby giving the appearance of an "empty sella." This empty sella is a relatively rare clinical entity which is being recognized more in recent years; to the best of our knowledge, no such cases have been reported in Hawaii. The purpose of this paper, therefore, is to present a personal series of 6 cases of the primary empty sella syndrome diagnosed over the past three years in Hawaii and to briefly review the literature on this subject.*

In 1951 Busch¹ noted in a series of 788 autopsies, 165 cases of absent sella diaphragms. Of these, 40 had sella enlargement, flattening of a normal or slightly enlarged pituitary on the sella floor, and an appearance of sella emptiness at autopsy. Moreover, the arachnoid space was

found to have been occupying those areas not filled by the pituitary. None of these patients had any previous history of pituitary or endocrine disease.

These findings were reaffirmed in 1968 by Bergland² in his own series of 225 autopsies. Since then, other studies³⁻⁵ have firmly established the primary empty sella syndrome as a true clinical entity.

Case Material

The following 6 cases of the primary empty sella syndrome have been documented over the past 3 years in Hawaii and their salient features are presented in Table 1.

Case 1: An obese 51-year-old woman presented with chronic nasal discharge and stuffiness of 3 years duration. Skull x-rays revealed an enlarged sella and she was consequently worked up to rule out a possible pituitary tumor.

TABLE 1.—Age, sex, symptoms and endocrine parameters in six cases of empty sella syndrome.

PATIENT	AGE	SEX	PRESENTING SYMPTOMS	T4 (4.7-10.7 μ G%)	RT3 (34-59%)	AM CORTISOL (7-27 μ G%)	AM GROWTH HORMONE (0-30 μ G%)	CORTISOL PEAK (μ G%)	GH PEAK (NG/CC)	FSH
Case #1, MM	52	F	Chronic nasal discharge & stuffiness	4.8	41.1	12	1.12	28	6	152
Case #2, KK	50	F	Headache	7.1	36.4	—	—	—	—	139
Case #3, GY	53	F	Chronic headache	8.5	42.2	10	2.5	22	6.8	—
Case #4, LR	35	F	Chronic headache	8.1	39	26	3.0	33	13.0	—
Case #5, RR	56	F	Headache	5.6 (4.5-11.5)	28 (26-36)	16.8	1.0	—	—	—
Case #6, JS	39	F	Chronic headache	6.7	39	20	2.3	*	*	—

*Induced hypoglycemia not sufficient due to insulin resistance

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Case 2: A 50-year-old woman with a past history of bilateral radical mastectomies complained of intermittent frontal headaches for 6 months. She was worked up for possible metastatic disease and was found to have an enlarged sella on skull x-ray.

Case 3: This 53-year-old hypertensive woman

(150/90) complained of chronic headaches for the past 3 years. Her sella was found to be enlarged on skull x-rays but her neurologic and pituitary endocrine functions were normal.

Case 4: A 34-year-old obese woman with hypertension (160/104) presented with headaches for 3 years duration and an enlarged sella on skull x-rays.

Case 5: This obese 56-year-old woman complained of having occipital headaches for 3 weeks and was found to have an enlarged sella on skull x-rays. Her pneumoencephalogram (Fig. 1) is typical for all cases in this series.

FIG. 1.—Typical entry of air into the sellar space.



Case 6: A 39-year-old obese, mildly hypertensive woman who complained of progressively increasing and frequent headaches over the past 6 years was found to have an enlarged sella on skull x-rays and opacification of the frontal and maxillary sinuses. Sufficient hypoglycemia to stimulate her cortisol and growth hormone secretion could

not be induced because of insulin resistance, evidenced by an elevated fasting insulin of 40 μ U/ml in the presence of a normal fasting blood sugar of 98 mg% and from a glucose tolerance test meeting the criteria for chemical diabetes. The visual fields, neurological examination and other endocrine studies were normal and a primary empty sella was later demonstrated.

Discussion

The primary empty sella is defined as the sella turcica that admits significant amounts of air at pneumoencephalography in the absence of prior pituitary surgery or irradiation therapy.³ (The word “primary” is used simply to distinguish the above condition from a “secondary” empty sella; ie, those which follow surgery or radiation procedures.) It has been noted that more than 80% of the patients with primary empty sellas are obese, middle-aged women who are mildly hypertensive and often have normal visual fields and pituitary endocrine function. Collectively, these characteristics make up what has been termed the primary empty sella syndrome. These patients frequently present with headaches and less commonly with spontaneous cerebrospinal fluid rhinorrhea, symptoms suggestive of sinus problems or mild abnormalities of pituitary endocrine function. In one study from Duke University, 8 of 31 patients with this syndrome had endocrine disturbances.⁵

All of our patients presented in a similar and uniform fashion. They were all middle-aged women with normal visual fields, neurologic and endocrine studies. The serum T4 and resin T3 uptake levels were normal in all 6 and random morning cortisol and growth hormone levels were normal in all of the 5 patients tested. The follicle-stimulating hormone level, which is a good screening test of pituitary endocrine function in post-menopausal women, was tested in only 2 of the 6 patients, but was physiologically elevated in both cases. Carotid angiograms and brain scans were normal in all of the patients tested (see Table 2). Three of the 6 were either obese or hypertensive and, like a majority of the patients in other studies, 5 presented with the chief complaint of headaches while only one presented with symptoms suggestive of chronic sinus problems. None of our patients presented with spontaneous cerebrospinal fluid rhinor-

TABLE 2.—Physical, x-ray, scan findings and follow-up in six cases of empty sella syndrome.

PATIENT	VISUAL FIELDS	NEURO EXAM	CAROTID ANGIOGRAMS	BRAIN SCAN	PEG	FOLLOWUP
Case #1, MM	Intact	Normal	Normal	—	Pos	24 mo
Case #2, KK	Intact	Normal	Normal	—	Pos	12 mo
Case #3, GY	Intact	Normal	—	—	Pos	14 mo
Case #4, LR	Intact	Normal	Normal	Normal	Pos	14 mo
Case #5, RR	Intact	Normal	—	Normal	Pos	30 mo
Case #6, JS	Intact	Normal	—	—	Pos	21 mo

rhea, and all have continued to do well after followup periods ranging from 14 months to 2 and ½ years.

It is now assumed from Busch's and Bergland's studies that incomplete development of the sella diaphragm is a prerequisite to the formation of a primary empty sella. The increased size of the opening for the pituitary stalk or complete absence of the diaphragm is regarded as a naturally occurring congenital variation. Over a long period of years the transmission of even mildly elevated cerebrospinal fluid pressure through this defect causes an intrusion of the subarachnoid space into the sellar cavity with subsequent enlargement and remodeling of the sella turcica and flattening of the pituitary gland against the floor.^{3,6} Thus, the finding of an enlarged sella that may admit air on pneumoencephalography.

A diagnosis can usually be made by a combination of pneumoencephalographic, endocrine, neurologic and visual field studies. In the case of a primary empty sella, pneumoencephalography with tomograms, with the patient in the brow-up or head-back positions, usually demonstrates air in the sella turcica; in the case of a chromophobe adenoma, however, the pneumoencephalogram reveals a soft tissue mass arising above the sella diaphragm with no air in the sella. Also, in contrast to primary empty sellas, chromophobe adenomas often present with endocrine abnormalities. Weisberg⁷ found in his study of 270 patients with adenomas, a loss of human growth hormone response to hypoglycemia in 90% of the cases, gonadotropic hormone loss in 67% and

adrenocorticotrophic hormone loss in 50%. Visual field defects, which occur rarely with primary empty sellas, are also much more common with expanding intrasellar tumors.^{5,6} A case of Cushing's disease in a patient with the primary empty sella syndrome has been described which can be considered an unusual coincidence without any causal relationship.⁸

Therefore, an enlarged sella turcica in the presence of normal endocrine function and significant amounts of intrasellar air on pneumoencephalography establishes a relatively benign prognosis. However, because of the nature of the pathology and uncertain clinical course with respect to preservation of endocrine function, a long-term follow-up is recommended.

If during the follow-up, there is any suspicion of a change in endocrine function, the primary empty sella syndrome is no reassurance that the pituitary will not be subject to any disease process that a normal pituitary in a normal sella can undergo.

Summary

The primary empty sella syndrome is in most cases a benign condition associated with few, if any, clinical signs and seldom results in derangement of pituitary endocrine functions. The importance of its recognition lies in differentiating it from an intra-sellar tumor, thereby establishing a more benign prognosis. It is stressed that all patients with an enlarged sella suspected of having an intra-sellar tumor should be submitted to a pneumoencephalogram prior to therapeutic consideration, whether it be surgery or radiation therapy.

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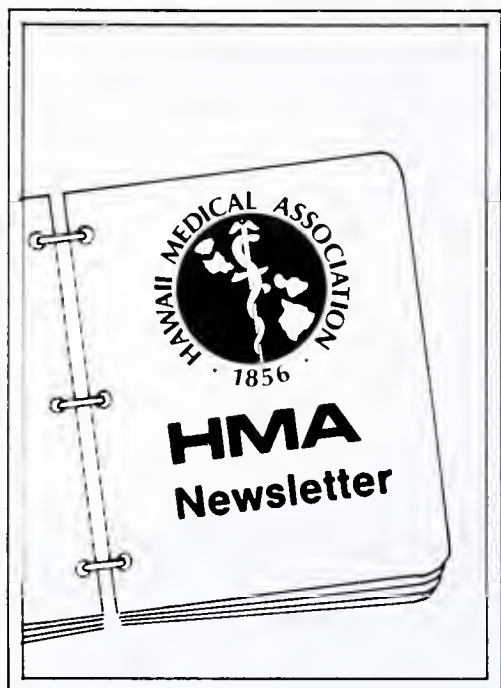
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JON WON

A Little Belated, but in July of this year, HMA received a letter from Jeremy Lam, M.D., M.P.H., Chief, School Health Branch, Dept. of Health, in which he expressed his gratitude to all HMA members for their enthusiastic support of the Statewide Vision and Hearing Screening Program during the past legislative session. As a result, Dr. Lam notes, the Program has been funded for another school year. This Program is concerned with the early identification of sensory deficits. If any HMA member wishes more information, contact the HMA office.

Massachusetts Medical Society is seeking a replacement for its Executive Vice-President, Dr. F. Thomas Gephart, who passed away on March 12, 1977, after ten years in his position. The bylaws of the Massachusetts Medical Society require that the Executive Vice-President (EVP) should be a physician, who is the chief administrative officer of the Society, answering directly to the President, and through the President, is responsible to the Executive Board of the Council and the Council itself. If any physician is interested in more information regarding this position, please contact the HMA office.

HMA Annual Meeting, Sheraton-Waikiki, October 30-November 4, 1977. The AMA is holding a regional CME Program in conjunction with our Annual Meeting. Mark these dates on your calendar and enjoy scientific education as well as participate in the affairs of YOUR medical association.

John H. Budd, M.D., President, American Medical Association, will be attending and participating in HMA's Annual Meeting this year. We are very happy he will be here and we want to extend our greatest aloha to him.

Graduation Ceremonies were held on September 23, 1977, for the eleventh and twelfth classes of Mobile Intensive Care Technicians and the third class of Mobile Intensive Care Technicians-Assistants of the HMA-EMS Program at the Mabel Smyth Auditorium. The physicians should be proud that their medical association is producing these physician support personnel that are of direct benefit to the public.

American Association of Medical Assistants, State of Hawaii Society, held its sixth Annual Educational Seminar on September 25, 1977, with this year's theme, "Continuing Education is a Lifelong Process Towards Professionalism." YOUR medical assistants heard from a number of excellent speakers on medical topics, malpractice, sex abuse treatment, medical emergencies, and the medical assistants association itself. This continuing education of medical assistants is designed to assist those personnel who make YOUR practice better and more efficient in order for you to better serve YOUR patients. If your medical assistants are not members of the AAMA, State of Hawaii Society, you might check into membership. You will find your support of the medical assistants return benefits to you many times over.

The Hawaiian Open Golf Tournament is still looking for physicians who will provide emergency coverage during the tournament. The tournament is hoping to find about five physicians to volunteer their services and split coverage. Each of the volunteers will be given a Hawaiian Open shirt and a badge which will permit free entry to the Open throughout the five days. Coverage needs to be provided 7:30 a.m. through 5:00 p.m., Wednesday, Thursday, and Friday, February 1, 2, and 3, 1978, and from 7:30 a.m. through 2:30 p.m. on Saturday and Sunday, February 4 and 5, 1978. Interested physicians call Dr. Neal Winn at 955-6324.

The Chief, Alcohol and Drug Abuse Branch, State Department of Health, wishes to alert all physicians of a health caution regarding Fetal Alcohol Syndrome put out by DHEW:

Recent research reports indicate that heavy use of alcohol by women during pregnancy may result in a pattern of abnormalities in the offspring, termed The Fetal Alcohol Syndrome, which consists of specific congenital and behavioral abnormalities. Studies undertaken in animals corroborate the initial observations in humans and indicate as well an increased incidence of stillbirths, resorptions and spontaneous abortions. Both the risk and the extent of abnormalities appear to be dose-related, increasing with higher alcohol intake during

AMA REGIONAL CONTINUING MEDICAL EDUCATION PROGRAM

HELD IN CONJUNCTION WITH
HAWAII MEDICAL ASSOCIATION

121st ANNUAL MEETING

Monday through Friday,
October 31 - November 4, 1977

SHERATON-WAIKIKI HOTEL

2255 KALAKAUA AVE.

HONOLULU, HAWAII 96815

As an organization accredited for continuing medical education, the American Medical Association certifies that the continuing medical education activities designated Category 1 meet the criteria for Category 1 on an hour-for-hour basis for the Physician's Recognition Award of the American Medical Association.

Monday, Oct. 31 through Wednesday, Nov. 2, 7:30-9:30 AM each day (6-hour, 3-day courses: \$70 each)

0-1. Basic Electrocardiography • Course is directed to the physician whose knowledge of electrocardiography is relatively limited. Fundamentals of electrocardiography will be developed in terms of modern concepts of myocardial electrophysiology and the projection of the electrical forces generated by the heart upon the surface of the body. Such subjects as electrophysiology of the myocardium and vector concepts, hypertrophy, intraventricular conduction defects and the hemiblocks, myocardial infarction, myocardial ischemia, cardiac arrhythmias, and artificial pacing of the heart will be discussed. **Faculty:** Robert M. Richard, MD, PhD, Los Angeles, Calif., course director. *Honolulu Room*

0-2. Pulmonary Function & Blood Gases • Course provides a problem-solving technique for applying pulmonary function tests and blood gas results to clinical problems. Four pathways are offered simultaneously: primary care, secondary care, tertiary care (pulmonary subspecialty), and pediatrics; and a pre-test assists the participant in his choice. Two booklets, "Interpretation of PFT" and "Principles of PFT" have been written for the course. **Faculty:** Douglas G. Massey, MD, course director; David Andrew, MD; Gisele Fournier, MD, PhD; and Michael Light, MD. *Kahuku Room*

0-3. Office Dermatology • After a photographic introduction to Hawaii where skin lesions are compared to mountains, flowers, lava formations, and other natural phenomenon, it will be practical, clinical dermatology. Diagnostic and therapeutic pearls ranging from Acne to Zoster will be covered. In-depth subjects will include atopic dermatitis, skin cancer, acne, leprosy, cutaneous manifestations of systemic diseases, and viral infections of the skin. The "Wiki-Wiki" (hurry-hurry) rounds will stimulate participants with rapid-fire gems dealing with internal and external skin disorders.

Faculty: Norman Goldstein, MD, Honolulu, Hi., course director; Harry L. Arnold, Jr., MD, Honolulu, Hi.; Wilma Bergfeld, MD, Cleveland, Ohio; S. William Levy, MD, San Francisco, Calif.; James P. Rotchford, MD, Arlington, Va.; and members of the Hawaii Dermatological Society. *Oahu Room*

0-4. Fluid & Electrolyte Balance • Fluid and electrolyte abnormalities are a common and recurring problem found by every practitioner in the care of the acutely or chronically ill patient. A practical, down-to-earth discussion of salt and water metabolism as it relates to clinical practice will be presented with special emphasis on recognition and treatment of the more common underlying pathophysiological states. **Faculty:** Jared Sugihara, MD, course director; Arnold Siemsen, MD; and Eugene Wong, MD. *Waialua Room*

0-5. Practical Office Management of Sexual Dissatisfaction • The aim of this program is to present an approach to sexual counseling that can be used by the professional, as a part of ordinary office practice, both to diagnose and treat couples with sexual problems. The program is designed for family practice physicians, and various appropriate audio and visual materials will be used throughout the presentation, with opportunities for questions and interaction with the faculty. **Faculty:** Ron Pion, MD, course director; Jack Annon, PhD; Gail Pion MSW; and Larry Reich, DO. *Waianae Room*

0-6. Rational Use of Antibiotics • A review of clinically important antimicrobial agents with emphasis on newer antibiotics, advantages over older agents, clinical indications, and toxicity. Course will also describe three major sections of antibiotic usage — aerobic gram-positive infections, aerobic gram-negative infections, and anaerobic infections. **Faculty:** Richard Frankel, MD, Honolulu, Hi., course director; William Lau, MD, Honolulu, Hi.; and Martin Raff, MD, Louisville, Ky. *Historical Room*

Monday, Oct. 31 through Wednesday, Nov. 2, 11:00 AM-1:00 PM each day (6-hour, 3-day courses: \$70 each)

0-7. Cardiovascular Disease: Diagnosis & Management of the Acute Patient • For most patients, acute chest pain, or premature ventricular contractions, can be very frightening. Reassurance and careful consideration of the proper sequence of the steps to take in diagnosis when confronted with these common symptoms will be discussed in the course. Occasionally arteriograms and other more serious measures are contemplated when less sophisticated tests and treatment would be routinely suggested by the cardiologist. A logical procedure will be developed for the acute patient. **Faculty:** Danelo Canete, MD, course director; Bruce E. Dunn, MD; Samuel Gresham, MD; James Orbison, MD; and Irwin Schatz, MD. *Honolulu Room*

0-8. Office Gynecology • Program will center around six common problems that are seen in the office. Topics will include amenorrhea, perimenopausal bleeding, estrogens, contraception update, vulval vaginitis, and management of selected precancerous lesions. Emphasis will be placed on current concepts of diagnosis and management, as well as the controversial aspects of the topics. Participants will be expected to ask questions and share their own experiences in these areas. **Faculty:** Ralph Hale, MD, Honolulu, Hi., course director; and Ralph Benson, MD, Portland, Ore. *Kahuku Room*

0-9. Infectious Diseases • Educational objective of this course is to update the general practitioner in newer developments in the area of common outpatient and hospital infections. Course will enable the office physician to make correct decisions concerning immunizations, diarrheal diseases, upper respiratory infections, venereal diseases, and common parasitic infections. Also, the problem of common nosocomial hospital infections will be discussed. **Faculty:** Francis D. Pien, MD, course director; Elizabeth Barrett-Connor, MD; and Raul Rudoy, MD. *Oahu Room*

0-10. Pediatric Emergencies • Objective of this program is to teach practicing pediatricians and primary care physicians a systematic and step-wise approach to the recognition and immediate management of a variety of pediatric emergencies. Surgical, infectious, respiratory, and newborn emergencies will be emphasized. **Faculty:** Robert A. Wiebe, MD, course director; Rodney C. Boychuk, MD; Michael Light, MD; Raul Rudoy, MD; and Walton K. T. Shim, MD. *Waialua Room*

0-11. Office ENT for the Family Physician • The objectives of the otolaryngology program are to review the ear, nose, and throat problems that the primary physicians will see in their daily practice. Emphasis will be on more recent diagnosis and treatment procedures that will be useful in office practice. **Faculty:** Kazuo Teruya, MD, course director; Truett Bennett, MD; Gene W. Doo, MD; Tom Van Sant, MD. *Waianae Room*

0-12. Marathon Therapy for Myocardial Insufficiency • The beneficial relationship of exercise modification of many of the risk factors associated with coronary artery disease has been well established in the literature. Yet at the same time controversy continues to exist surrounding the merits of recreational long-distance running and the treatment of myocardial insufficiency. Purpose of this course,

therefore, is not to provide the final solution, but rather to discuss the theoretic implications and possible merits of long-distance running (i.e., habitual physical activity) in individuals with presumed or overt coronary artery disease and finally to discuss means of implementing such a program in a sound and rational fashion. **Faculty:** Jack H. Scaff, Jr., MD, course director; William H. Bruce, MD; Alfred D. Morris, MD; and John O. Wagner, MD — all from Honolulu, Hi.; and Rudolf H. Dressendorfer, PhD, David, Calif. *Historical Room*

Thursday & Friday, Nov. 3 & 4, 7:30-10:30 AM each day (6-hour, 2-day courses: \$70 each)

0-13. Basic Electrocardiography • Repeat of Course 0-1; see page 2 for course description. The same faculty will present the course. *Honolulu Room*

0-14. Office Dermatology • Repeat of Course 0-3; see page 2 for course description. The same faculty will present the course. *Kahuku Room*

0-15. Fluid & Electrolyte Balance • Repeat of Course 0-4; see page 3 for course description. The same faculty will present the course. *Oahu Room*

0-16. Cardiovascular Disease: Diagnosis & Management of the Acute Patient • Repeat of Course 0-7; see page 3 for course description. The same faculty will present the course. *Waialua Room*

0-17. Practice Management Seminar • Good business management is essential to secure. Course is designed to help increase practice efficiency, covering latest management techniques: personnel recruitment; hiring; training and supervision; business office procedures — task analysis, billing, collections, filing, and medical records; physical layout and space needs of a medical office; patient information booklet; telephone control; and appointment scheduling. Time allowed for questions and answers. **Faculty:** Maynard L. Heacox and Gerald L. Farley, co-course directors, AMA-Chicago, Ill. *Waianae Room*

Thursday, Nov. 3, 7:30 AM-1:00 PM (6-hour, 1-day course: \$65)

0-18. Mastering Spokesmanship Principles • An accelerated course for medical society officers and spokesmen exclusively concentrated on practical principles and discussion of news media relations and how to handle yourself in news interview situations, print, radio, or television. **Faculty:** Mortimer T. Enright, course director, AMA-Chicago, Ill. *Waimea Canyon Room*

Friday, Nov. 4, 7:30 AM-1:00 PM (6-hour, 1-day course: \$65)

0-19. Mastering Spokesmanship Principles • Repeat of Course 0-18; see above course description. The same faculty will present the course. *Waimea Canyon Room*

Monday, Oct. 31, 7:30 AM-Noon (5-hour, 1-day course: \$55)

0-20. Basic Life Support (Cardiopulmonary Resuscitation — CPR) • In cooperation with the American Heart Association, Hawaii Affiliate, course will cover early warning

signs and signals for survival from sudden respiratory and cardiac arrest. The practical skills in the management of one- and two-person CPR; infant resuscitation; relief of an obstructed airway; and unwitnessed cardiac arrest will be covered. A method of entry into your local emergency medical care system will be discussed. Course participants may be certified by obtaining 85% on the written examination and near-perfect performance in the practical skills mentioned above. **Faculty:** Representatives of the American Heart Association, Hawaii Affiliate, Russell Carlson, MD, Honolulu, Hi., course director. *Niihau Room*

Tuesday, Nov. 1 through Thursday, Nov. 3, 7:30 AM-Noon each day (13-hour, 3-day course: \$145)

0-21. Advanced Life Support (Cardiopulmonary Resuscitation — CPR) • Certification in Basic Life Support is a prerequisite for this course. In cooperation with the American Heart Association, Hawaii Affiliate, ACLS course provides instruction in the following: use of adjunctive equipment; arrhythmia recognition and cardiac monitoring; defibrillation and cardioversion; establishing and maintaining intravenous fluid life-lines; drug therapy to correct acidosis, shock, and serious arrhythmias; and stabilization of the patient's condition for transportation. Registrants will be certified according to the standards of the American Heart Association. **Faculty:** Representatives of the American Heart Association, Hawaii Affiliate, Russell Carlson, MD. *Niihau Room*

Friday, Nov. 4, 7:30 AM-Noon (5-hour, 1-day course: \$55)

0-22. Basic Life Support (Cardiopulmonary Resuscitation — CPR) • Repeat of Course 0-20; see above course description. The same faculty will present the course. *Niihau Room*

STATE-OF-THE-ART LECTURES AND PLENARY SESSIONS

MOLOKAI ROOM
Category 2 CME Credit

These sessions require no fee from Hawaii Medical Association members. For non-HMA members your \$25 registration fee will permit you to attend.

MONDAY, OCTOBER 31

7:30-9:30 a.m.

Plenary Session

Recent Advances in Surgery

Thomas J. Whelan, Jr., M.D., Moderator

9:45-10:45 a.m.

State-of-the-Art Lecture

Exercise and Heart Diseases: Etiologic Approach

Jack Scaff, M.D.

11 a.m.-1 p.m.

Clinical Depression: An Historical Perspective and Current Concepts of Diagnosis (a movie)

This course is sponsored by the University of Pennsylvania through a grant from Pfizer Laboratories.

TUESDAY, NOVEMBER 1

7:30-9:30 a.m.

Plenary Session

Current Topics in Internal Medicine

Christian L. Gulbrandsen, M.D., Moderator

9:45-10:45 a.m.

State-of-the-Art Lecture

Native Hawaiian Medical Profession before 1800

O. A. Bushnell, Ph.D.

11 a.m.-1 p.m.

Clinical Depression (Repeat of Monday, see above.)

WEDNESDAY, NOVEMBER 2

7:30-9:30 a.m.

Plenary Session

Oahu Emergency Medical Care—1977

Livingston M. F. Wong, M.D., Moderator

Oahu EMS System Overview

U.S. EMS Systems

Pre-hospital Emergency Care

9:45-10:45 a.m.

State-of-the-Art Lectures

I. MAST Trousers

Leslie Bowker, MICT, Livingston Wong, M.D.

II. Blood Filters

J. Judson McNamara, M.D.

III. Ruptured Achilles Tendon Repair—New Closed Method

Gabriel W. C. Ma, M.D.

11 a.m.-1 p.m.

Plenary Session

Emergency Care of the Hospitalized Patient

EMS Statistics

THURSDAY, NOVEMBER 3

7:30-10:30 a.m.

Plenary Session

Current Topics in Pediatrics

Sherrel L. Hammer, M.D., Moderator

11 a.m.-Noon.

State-of-the-Art Lecture

Frontiers of Healing

Philip Jones, M.D.

FRIDAY, NOVEMBER 4

7:30-10:30 a.m.

Plenary Session

Current Topics in Obstetrics and Gynecology

Ralph W. Hale, M.D., Moderator

11 a.m.-Noon.

State-of-the-Art Lecture

Compliance and Informed Consent

Ronald Pion, M.D.

CONTINUOUS MOVIES—Puna Room

Monday through Friday, October 31 to November 4, 8 a.m. to Noon. A selection of recently produced movies on various medical topics will be shown. (A list of titles for these movies and the times they will be shown will be available in the final program.)

HAWAII THORACIC SOCIETY

Fireside Chat Conference

November 1, 7:30 p.m.

Oahu/Waialua Rooms

"Diagnostic Procedures in Lung Diseases"

Adam Wanner, M.D.

"Tuberculosis in Hawaii"

Panel: Adam Wanner, M.D., Lee Roy Joyner, M.D.,

Kirsten Vennesland, M.D.

COURSE REGISTRATION FOR HAWAII PHYSICIANS

(Registration is limited for all courses.)

Please return to:

AMA DEPARTMENT OF MEETING SERVICES
535 North Dearborn Street
Chicago, Illinois 60610
Phone inquiries: (312) 751-6503

Even if you do **not** wish to register for postgraduate courses, but wish to attend plenary sessions and State-of-the-Art lectures, please pre-register by signing your name at the bottom of this registration sheet and send it to the HMA office, 320 Ward Avenue, Suite 200, Honolulu, HI 96814.

NOTE: A group breakfast will be provided for all postgraduate course registrants from Monday through Friday in the Kauai Room from 6:45-7:30 a.m.

COURSE PREFERENCES*	Number Order of Preferences Mon. Tue. Wed. Thur. Fri.	COURSE PREFERENCES*	Number Order of Preferences Mon. Tue. Wed. Thur. Fri.
0-1. Basic Electrocardiography (\$70) _____		0-15. Fluid & Electrolyte Balance (\$70) _____	
0-2. Pulmonary Function & Blood Gases (\$70) _____		0-16. Cardiovascular Disease: Diagnosis & Management of the Acute Patient (\$70) _____	
0-3. Office Dermatology (\$70) _____		0-17. Practice Management Seminar (\$70) _____	
0-4. Fluid & Electrolyte Balance (\$70) _____		0-18. Mastering Spokesmanship Principles (\$65) _____	
0-5. Practical Office Management of Sexual Dissatisfaction (\$70) _____		0-19. Mastering Spokesmanship Principles (\$65) _____	
0-6. Rational Use of Antibiotics (\$70) _____		0-20. Basic Life Support—CPR (\$55) _____	
0-7. Cardiovascular Disease: Diagnosis & Management of the Acute Patient (\$70) _____		0-21. Advance Life Support— CPR (\$145) _____	
0-8. Office Gynecology (\$70) _____		0-22. Basic Life Support—CPR (\$55) _____	
0-9. Infectious Disease (\$70) _____			
0-10. Pediatric Emergencies (\$70) _____		Add \$15 if not AMA member: _____	
0-11. Office ENT for the Family Physician (\$70) _____		Add \$25 if not HMA member: _____	
0-12. Marathon Therapy for Myo- cardial Insufficiency (\$70) _____		(Not applicable to residents, interns and students)	
0-13. Basic Electrocardiography (\$70) _____		If you wish to register only for the State-of-the-Art Lectures: _____ No Fee	
0-14. Office Dermatology (\$70) _____			
		TOTAL COURSE FEE REMITTANCE: \$ _____	

*Courses 0-1 through 0-12 are each 6-hour, 3-day courses: \$70 each. Courses 0-13 through 0-17 are each 6-hour, 2-day courses: \$70 each. Courses 0-18 and 0-19 are each 6-hour, 1-day courses: \$65 each. Courses 0-20 and 0-22 are each 5-hour, 1-day courses: \$55 each. Course 0-21 is a 13-hour, 3-day course: \$145.

All residents, interns and medical students are entitled to a 50% discount on course registration fees (\$10 per credit hour is standard rate).

Name _____
(please print or type)

Office Address _____

City/State/Zip Code _____

Office Phone No. () _____

the pregnancy period. In human studies, alcohol is an unequivocal factor when the full pattern of the Fetal Alcohol Syndrome is present. In cases where all of the characteristics are not present, the correlation between alcohol and the adverse effects is complicated by such factors as nutrition, smoking, caffeine and other drug consumption.

Given the total evidence available at this time, pregnant women should be particularly conscious of the extent of their drinking. While safe levels of drinking are unknown, it appears that a risk is established with ingestion above 3 ounces of absolute alcohol or 6 drinks per day. Between 1 ounce and 3 ounces, there is still uncertainty but caution is advised. Therefore, pregnant women and those likely to become pregnant should discuss their drinking habits and the potential dangers with their physicians.

The Department of Pediatrics, John A. Burns School of Medicine, Kauaikeolani Children's Hospital is seeking a full-time associate professor to begin approximately Oct. 1, 1977. Duties: to assume responsibility for medical students and housestaff training in pediatrics infectious diseases. Minimum Qualifications: minimum of five years experience in laboratory and clinical research in pediatric infectious disease and teaching; board certified pediatrician. Send CV's to: S. L. Hammar, M.D., Kauaikeolani Children's Hospital, 226 No. Kuakini St., Honolulu, Hawaii 96817.

Physicians: The United States Air Force Medical Corps has immediate openings for primary care physicians. This is an opportunity to practice clinical medicine with 30 days of paid vacation each year. Contact: Capt. Carl L. Newell, USAF, MSC; USAF Medical Placement Office; 620 Central Ave.; Alameda, California 94501.

Board Eligible Internist will be available for part- or full-time work after November 1, 1977. Contact HMA office for details.



"Now that's what I call a booster shot!"



Why organized medicine?

None of us denies that a physician is primarily involved in the care of his patient.

The doctor zeros in on his patient's problem(s) and then prescribes a cure, be he generalist or specialist. This he does on the basis of his training, ability and experience, often in consultation with his colleagues whom he considers to be more expert than himself. This is applied equally to acute medical and surgical, and also psychic crises, and to long-term health maintenance. Be it remembered, with reference to the latter situation, that, contrary to the spiels of the do-gooders and reformists that emanate largely from Washington, health maintenance—the prevention of these crises—occupies nearly half the physician's time.

The physician "practices" his profession in the sense that he is forever learning from the experience with one patient applied to the problem of the next one. This is what CME is all about, CME being the acronym for the learning process that pervades a physician's lifetime—which acronym has become the *bon mot* of the medical bureaucracy of late. Some doctors spend their extra time reading books and journals; they keep themselves just as current in medical knowledge, quietly browsing, unrecognized, as do the others who flaunt their "P" credits or PRA certificates. The latter medico attends (but often sleeps through) expensive courses (but deductible from income tax) and seminars and symposia in Bali or Timbuktu or at the Sheraton/Waikiki.

Unfortunately, there are also MD's who stagnate, who learn nothing that is new, who repeat and perpetuate their ineptitude—who do not "practice" in the sense of "to make perfect." And, although over a period of time their reputations suffer, rightfully, the public is generally too gullible and unknowing to steer clear of such aberrants. It is with these members of our profession that "Organized Medicine" is concerned. If each of us performs well, we would need no organization!

Despite the high standards the profession has imposed on itself in the way of accreditation of medical schools, of hospital residencies; despite the specialty board examinations and certification and recertification; despite CME coming more and more to be required even for relicensure, the true *raison d'être* for Organized Medicine is to "police" its rank and file members. And yet, as these high standards become commonplace, the need for internally-directed effort is diminishing.

Organized Medicine's main thrust is now becoming redirected towards defending the profession against the onslaught of the social-welfare reformists. And what do the latter want? When you boil it all down to the nitty-gritty, they want cheap mediocrity in medical care as in all other aspects of human existence. And here is where most physicians draw the line.

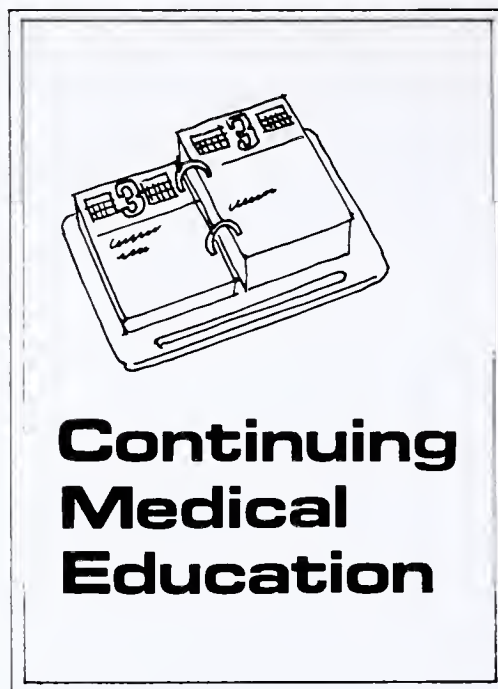
Physicians do not like to take time out from patient-care—to lobby, to serve on PSRO that is government-inspired, to do hospital staff busy-work merely to fulfill JCAH requirements (also government-inspired).

Yet it has to be done, this socio-economic defense of Medicine. No one else can perform the service for us to the extent that we can. Therefore, it behooves us to support the well-founded organizations we already have to serve us, and to participate whenever and wherever we can, without sacrificing patient-care.

Physicians in Hawaii are fortunate in having a member on the AMA's Board of Directors for once. We now have direct representation at the highest level of organized medicine. Our man is George Mills MD.

The Hawaii Academy of Family Physicians is supporting the candidacy of Felix Lafferty MD to a seat on the Board of Directors of the AAFP—the second largest organization of physicians in the USA. Felix is dedicated to the proposition that organized medicine is needed and is necessary for the survival of the best system of medical care in the world.

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1 1/4 hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

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MEMBER

National Selected Morticians, National Funeral Directors Association,
Order of the Golden Rule, Hawaii Funeral Directors Association

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

1. Medical Lecture, Tuesday, Oct. 11, 1:00-2:00 p.m.
2. Medical Mortality & Morbidity, 4th Tues., 1:00-2:00 p.m.
3. Endocrine Conf., 2nd Wed., 1:00-2:00 p.m.
4. Oncology Conf., Every Thurs., 7:30-8:30 a.m.
5. Surgical Conf., Every Fri., 1:00-2:00 p.m.
6. Surgical Mortality & Morbidity, 4th Fri., 1:00-2:00 p.m.

(Contact: CME Dept.-Kuakini for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m.
(Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professors' Program.

St. Francis Hospital

1. Medical Grand Rounds, Tuesday (4th & 5th) 12:30-1:30 p.m. Sull. 1V Classroom
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.

7. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Honolulu County Medical Society and Local Hospitals, Honolulu

Type: 1, 1 hr/day, 1 day/mo from 12 mos

Fee: None Methods: AV, O, Pan

Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

Type: 1, 1 hr/day, 1 day/mo for 8 mos

Fee: None Methods: AV, Clin C, O, Pan, R

Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

Oct. 1-8, 1977 Cardiology, USC at Mauna Kea Beach Htl., Kamuela, HI. 1 week.

Oct. 6-9, 1977 Clinical Pharmacology, UCSF at Hilo, HI. Thurs.-Sat.

Oct. 8-15, 1977 Endocrinology/Nephrology, USC at Mauna Kea Beach Htl., Kamuela, HI. 1 week.

Oct. 8-16, 1977 Body Imaging Conf.-2nd Annual, West Park Hsp. Canoga Park. Held at Kauai Surf Htl., Kauai, HI. One week.

Oct. 10-14, 1977 Practical Electrocardiography, Mem. Hsp. Med. Cntr. of Long Beach. Held at Hotel InterContinental, Maui, HI. Mon.-Fri.

Oct. 15-22, 1977 Pediatrics for the Practitioner, Chldrn's Hsp. of Long Beach & Am. Academy of Ped.-Chapter 2. Held at Mauna Kea Beach Htl., Kamuela, HI. One week.

Oct. 18-Nov. 22-Dec. 7-1977 "Advanced Trauma Life Support (ATLS) Trauma Lab Courses for emergency physicians." 1-6 P.M. Rm. C-208, 2nd Flr. Biomedical Bldg. Schl. of Med U of HI. Contact: J.K. Sims, M.D. EMS (808) 547-4471.

Oct. 24, 25, 1977 "Advanced Cardiac Life Support"-8:00 a.m.-5:00 p.m. Queen's Med. Cntr. Contact: J.K. Sims, M.D.-EMS/CME-Queen's (808) 538-9011.

Oct. 31, Nov. 4, 1977 HMA Annual Mtg.-AMA Regional. Sheraton-Waikiki, Honolulu, Contact: Mrs. Bess Chang -HMA 320 Ward Ave. S 200, Honolulu 96814 or (808) 536-7702.

Oct. 31-Nov. 5, 1977 Visiting Prof. Prgm-HI Thoracic Soc. & Am. Lung Assoc. Major hsp on Oahu, Kauai, Maui & HI—6 days-6 hrs.

- Oct. 31-
Dec. 6, 1977 Diving Med.-Univ. of HI Schl. of Med. 1960
E-West Rd. Honolulu, 96822. Held at King
Apr. 23-30, 1978 Kamehameha Htl. on Kailua-Kona. Fee \$225.
- Nov. 1,
1977 HI Thoracic Soc. Annual Mtg. Fireside Chat
Conf. 7:30 p.m.-Oahu/Waialua Rms.-Shera-
ton Waikiki Htl. "Diagnostic Procedures in
Lung Disease"-Speaker: Adam Wanner, M.D.
"Tuberculosis in HI"-Panel.
- Nov. 2-5,
1977 American Academy of Neurological Surgery,
Dr. John Lowrey, 888 So. King St., Honolulu,
HI 96813. Hdq. Hotel: Mauna Kea Beach.
Agent: Not appointed.
- Nov. 12-14,
1977 Comprehensive Laparoscopy: Current Prin-
ciples & Practice, UCSD at Kona Kai Club,
Kona, HI. Sat.-Mon.
- Nov. 12-19,
1977 Workshops High Risk Pregnancy: Infertility,
UCSF at Royal Lahaina Htl., Maui, HI. One
week.
- Nov. 13-15,
1977 Endocrinology & Fertility at Kauai Surf Htl.,
Kauai, HI. 3 days-12 hrs. U of Cal Extended
Prgrms in Med Educ, 3rd and Parnassus Ave.
S.F. CA 94143.
- Nov. 15-16,
17, 1977 Hyberbaric Med. Course-U of HI Schl. of
Med. Held at Mabel Smyth Aud. Speaker:
Eric Kindwall, M.D. 3 days-21 hrs. CME Cat. 1,
10:00a.m.-6:00p.m. Contact: Ed Beckman,
M.D. (808) 948-8652 for further info.
- Nov. 26-30,
1977 Lymphoproliferative Disorders, USC at
Mauna Kea Beach Htl., Kamuela, HI. One
week.
- Nov. 27,
Dec. 2,
1977 "Ultrasound of the Eye and Orbit" Seminar.
Waikiki Sheraton & Tripler AMC. Univ. of
Iowa & Tripler. CME Cat. 1-21 credits. Con-
tact: Philip M. Corboy, M.D. Co-ord. (808)
923-4734.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



Friday, March 4, 1977, 5:30 p.m.
HMA Meeting Room

CALL TO ORDER

The meeting was called to order by President Calvin C.J. Sia. Also present were Drs. William W.L. Dang,

Douglas B. Bell II, Grover H. Batten, Marion Hanlon, George H. Mills, Herbert Y.H. Chinn, Ann B. Catts, William Kepler, Richard Lundborg, Thatcher Magoun, Albert Chun-Hoon, George Goto, J.I.F. Reppun, Leonard Howard, John W. Edwards, Jr., Calvin C.M. Kam, Rowlin Lichter, Sakae Uehara, and Verne Adams plus Drs. Roy Kuboyama, William Moore, Paul Condit and Mr. V. Thomas Rice.

MINUTES

The minutes of the February 4, 1977 meeting were approved as circulated.

SPECIAL GUEST

Mr. Harry Rahr and Mr. Norman Slaustas, representatives of the Hawaii Medical Group Management Association and HAPI, a proposed physician's cooperative, met with the Council to describe the concept of the physician's cooperative and the enabling legislation for cooperatives presently under consideration by the Hawaii State Legislature. Brochures describing the plan in detail are available for review at the HMA office. Dr. Sia announced that the executive committee of HMA met and voted to support the enabling legislation for physician's cooperatives noting that this concept is one alternative to solving the problems of malpractice insurance costs.

ACTION:

It was voted to endorse the action of the HMA Executive Committee in its support of the enabling legislation for physician's cooperatives.

REPORT OF THE TREASURER

A. January 1977 Financial Statement: The treasurer reviewed the January 1977 financial statement in detail. The financial statement for the Community Research Bureau for the period ending January 1977 was also presented and reviewed.

ACTION:

It was voted to approve the January 1977 financial statements for the HMA, Community Research Bureau, and Building Fund subject to audit.

B. HMA/HCMS Contract for 1977: At the 1976 meeting of the HMA House of Delegates, it was agreed that the Honolulu County Medical Society would contract services from the HMA based on an annual agreement and that what was formerly known as the Common fund would be dissolved. A proposed agreement was circulated for Council review. The total proposed was based on the former sharing basis of the Common Fund, that is, the total operating budget was divided on the basis of staff time studies of 60% HMA—40% HCMS. It was questioned whether it might be possible to set up the contract according to the fixed assets and ongoing utilization expenses. This matter will be considered by the Operations Committee who will oversee the provisions of the agreement and be responsible for the evaluation of the personnel services and other items supplied by the HMA. It was also recommended that neighbor island representatives be invited to participate in the discussions of the Operations Committee.

ACTION:

It was voted to consummate the agreement as presented.

C. AMSA Request: The American Medical Student Association chapter at the University of Hawaii re-

Now ... the AMA brings CME to you!

As you're aware, state medical societies, specialty societies, and other medical groups in increasing numbers are making continuing medical education (CME) a requirement for membership. Already some state licensure boards are requiring CME for relicensure.

Recognizing its importance to members, the AMA has greatly expanded its CME programming. In 1977, your AMA will offer 15 regional meetings, as well as scientific programs at the Annual convention and Winter Meeting.

These new regional meetings make it easier, more convenient for you to fulfill your CME needs by bringing the programs closer to your home-

town and scheduling them on weekends to avoid interference with your practice.

All courses are approved by the AMA Council on Continuing Medical Education as meeting the criteria for Category 1 toward the AMA Physician's Recognition Award, which certifies completion of 150 hours of CME over three years. Since the initiation of the PRA program in 1969, more than 58,000 physicians have qualified and/or requalified for the award.

CME is just one of the many vital services the AMA provides for its members. With your support, it can do even more.

CME



**Join us.
We can do much more together.**

Dept. of Membership Development
American Medical Association
535 N. Dearborn St./Chicago, IL 60610

Please send me more information on the AMA
and AMA membership.

Name _____

Address _____

City/State/Zip _____

requested financial assistance from the HMA for the purpose of sending delegates to their national convention in April. It was agreed that medical students as well as interns and residents should be encouraged to become involved in organized medicine.

ACTION:

It was voted to contribute \$500 to the UH Chapter of the AMSA asking that the student representatives attend a Council meeting after the convention.

D. June AMA Meeting: It has been the custom for the Hawaii delegation to the AMA to host a hospitality room at the west coast meetings of the AMA. It was recommended that HMA host one two-hour reception at the convention.

ACTION:

It was voted to have a hospitality room at the AMA Convention and that not more than \$2,000 be spent.

E. HMA/AMA Meeting: The Finance Committee reported that they had been in contact with the AMA regarding the registration fee for the HMA/AMA Meeting in November and recommended no change in the previously approved fee of \$50 for non-HMA members.

REPORTS FROM COMMITTEES AND COMMISSIONS

A. EMS: Dr. Sia reported that the director of the EMS Program, Dr. Livingston Wong, had submitted his resignation as director effective June 30, 1977. He recommended that Dr. William W.L. Dang be affirmed by the Council as Director of the EMS Program.

ACTION:

It was voted to affirm Dr. Dang as Director of the EMS Program, effective June 30, 1977.

Dr. Dang reported that the EMS staff has prepared a grant for future training.

ACTION:

It was voted to support the grant as necessary.

ACTION:

It was voted to send a letter of appreciation to Dr. Wong thanking him for his past work as Director and ask that he continue to serve as a consultant to the program.

Several months ago, the HMA Council referred the matter of endorsement of a medic data card to the executive committee of the EMS Program. The EMS Board recommends that HMA not endorse medic data cards or commercial ventures of this nature.

ACTION:

It was voted to accept the recommendation of the EMS Board not to endorse medical data cards or commercial ventures of this nature.

B. Cancer Center Liaison: Dr. Condit reported that the ad hoc committee on Cancer Center Liaison has continued their discussion and should have some recommendations to present at the next Council meeting.

C. Cancer Commission: The Cancer Commission members have been involved in appearing at legislative hearings on several cancer bills which would affect the Hawaii Tumor Registry.

D. Legislation: Copies of HMA testimony presented at various legislative hearings were circulated to the Council. Due to the excessive demands upon the legislative counsel, it was recommended that his fee be increased \$1,000.

ACTION:

It was voted to increase the fee of the legislative counsel by \$1,000.

E. Act 219, Ad Hoc Committee: Dr. Howard reported that the committee had reviewed the first drafts of the bills to amend Act 219 which were presented to the entire Legislature for consideration as a result of legislative hearings. The initial drafts include most of the points sought by the HMA committee. It was noted that it may be necessary to modify the committee's position in regard to several of the points.

ACTION:

It was voted to affirm the actions of the Ad Hoc Committee on Act 219 in modifying the HMA position as necessary.

F. CME: Dr. Ho presented the CME Committee recommendations for CME requirements for HMA membership as well as recommendations for consideration by the Board of Medical Examiners. The committee recommends that the start up date be 1980. There was some question regarding the language relating to specialty societies and thus action was postponed until the next meeting.

G. Reports from the County Medical Societies: Dr. Lundborg reported that Hawaii County has held meetings to discuss the problems associated with "going bare" or without insurance and has met with the Media Council to discuss the relationship between the media and physicians. The county has reactivated their committee and will begin to develop written guidelines on media relationships. He invited members of the Council to attend the April 16 meeting which will be held at the Kona Surf.

Maui County has been reviewing their corporate status and bylaws. Kauai County has a few physicians who are interested in forming an independent society and this matter is being discussed there.

OLD BUSINESS

A. AMA Legislative Committee: Dr. Mills reported that he had attended the AMA Legislative Council meeting in Washington, D.C. The Council discussed amendments to the PSRO law and physician extender services. He noted also that the AMA Judicial Council will reprint the Judicial Opinions in the near future and will provide the county societies with copies.

B. HAMPAC: Dr. Howard reported that there are presently 158 members of HAMPAC. The HAMPAC Board will continue to encourage membership.

NEW BUSINESS

A. Meetings: Dr. Sia reported that the Executive Committee had met with the medical directors of HMSA. They discussed various mutual concerns including peer review and legislation.

B. New Committee: Dr. J.I.F. Reppun has been asked to chair an ad hoc committee which will look into discriminatory practices of insurance carriers.

C. Fee Survey: The HMA Fee Survey Committee is proceeding with their plans to publish a new relative value studies. There had been some concern regarding this publication at the last House of Delegates meeting. It was noted that several states are pursuing their studies and it was recommended that HMA continue to plan for a revision of the RVS.

ADJOURNMENT

The meeting adjourned at 9:45 p.m. The next meeting will be held on April 1.

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Wednesday, May 25, 1977, 6 p.m.
HMA Conference Room

CALL TO ORDER

The meeting was called to order by President Calvin C. J. Sia. Also present were Drs. William Dang, Douglas Bell II, Grover Batten, Marion Hanlon, Herbert Y. H. Chinn, William Kepler, Ann Catts, Richard Lundborg, John Edwards Jr., and Sakae Uehara. Seated as Councillors *pro tem* were Drs. Edgar Ho for Albert Chun-Hoon, Verne Waite for George Goto, Henry Oyama for Leonard Howard, Carl Boyer for Calvin Kam, Donald Char for Rowlin Lichter, Roy Kuboyama for J. I. F. Reppun, Elmer Johnson for George Mills. Also present were Dr. Douglas Yamamura, Chancellor of the Manoa Campus; Dr. Lawrence Piette, Executive Director of the Cancer Center of Hawaii; Dr. Noboru Oishi, Director Clinical Sciences Unit-CCH; Mr. James Bunker, Executive Director of the American Cancer Society, Hawaii Division; and Mr. V. Thomas Rice, HMA Attorney.

MINUTES

The minutes of the May 6, 1977 meeting of the HMA Council were approved as circulated.

A. CANCER CENTER OF HAWAII

Dr. Sia referred to his memorandum to the Council dated May 16, 1977 which outlined his meeting with National Cancer Institute site visitors who were in Honolulu to review the final plans for the Cancer Research Center Core Grant, the Cancer Center Building, and the Data Computation Research Program. Those present at that meeting had indicated their concern that the entire cancer program in Hawaii might be jeopardized if the Hawaii Tumor Registry were not located within the Cancer Center building at Queen's Medical Center.

Dr. Sia introduced the guests present and noted that he had invited the entire HMA Cancer Committee and Cancer Commission, representatives from the University of Hawaii, representatives from the Cancer Center of Hawaii, the American Cancer Society-Hawaii Division, the Department of Health, and the Hospital Association of Hawaii to attend the meeting in an effort to hear all aspects and opinions regarding the Cancer Center program, the Cancer Center of Hawaii building, and the HMA position of May 6, 1977 expressed to President Fujio Matsuda of the University of Hawaii that the HMA does not plan to move the Hawaii Tumor Registry to the proposed Cancer Center building. All who wished to address the issue were asked to do so.

During the discussion the role of the Executive Committee of the Cancer Center was outlined as it has been previously agreed upon at a meeting with UH President Matsuda. There were questions regarding the line of authority for decisions within the HMA structure and the relationship between the HMA, the HMA Cancer Commission, and the HMA Hawaii Tumor Registry.

The objectives of the SEER (Surveillance, Epidemiology, and End Results) program of the National Cancer Institute were discussed by the Project Director of the Cancer Center and the relationship between the SEER program and the Hawaii Tumor

Registry was discussed in detail. It was noted that the site visitors gave the impression that the Hawaii Tumor Registry could be dropped from the SEER program if the HTR were not housed in the Cancer Center building.

The position of the Cancer Society was expressed by its president, Dr. Reginald Ho, who noted that the American Cancer Society has not dealt specifically with the housing of the Hawaii Tumor Registry. They do support a community-based cancer program that is for the good of the community and believe the society should try to get all segments of the community to cooperate to effect a successful community-based cancer center program. He noted that he had not been convinced by the Cancer Center that the HTR needed to be based in the Cancer Center building; however, he also has not been convinced by the HMA's point of view. He recommended that the Cancer Commission should be the body to decide the issue of the move of the HTR.

Dr. Verne Waite noted that the Department of Health has been vitally interested in the idea of a cancer center for a number of years and they would not like to see the center fail because of the location of the Hawaii Tumor Registry. He noted that regardless of where the HTR is located, the Cancer Commission is constituted by law and the authority for release of information is also spelled out in the law.

Dr. Douglas Yamamura asked that the Council keep in mind that whatever decision is reached is related not only to the medical community but to the general public as well. He noted that the University of Hawaii is willing to work with the HMA, to clear lines of communication so that problems will not occur in the future. He discussed his reaction to the site visit and noted that he believed it went very well. He noted that the University of Hawaii has until July 1, 1977 to communicate with the site team regarding the decision on the location of the Tumor Registry.

In an executive session of the Council, the Council reviewed the earlier discussion. HMA's attorney discussed the Hawaii Tumor Registry's status as a legal entity.

ACTION:

It was voted to incorporate the Hawaii Tumor Registry as a subsidiary membership corporation of the HMA and that the necessary papers for incorporation be prepared within one week.

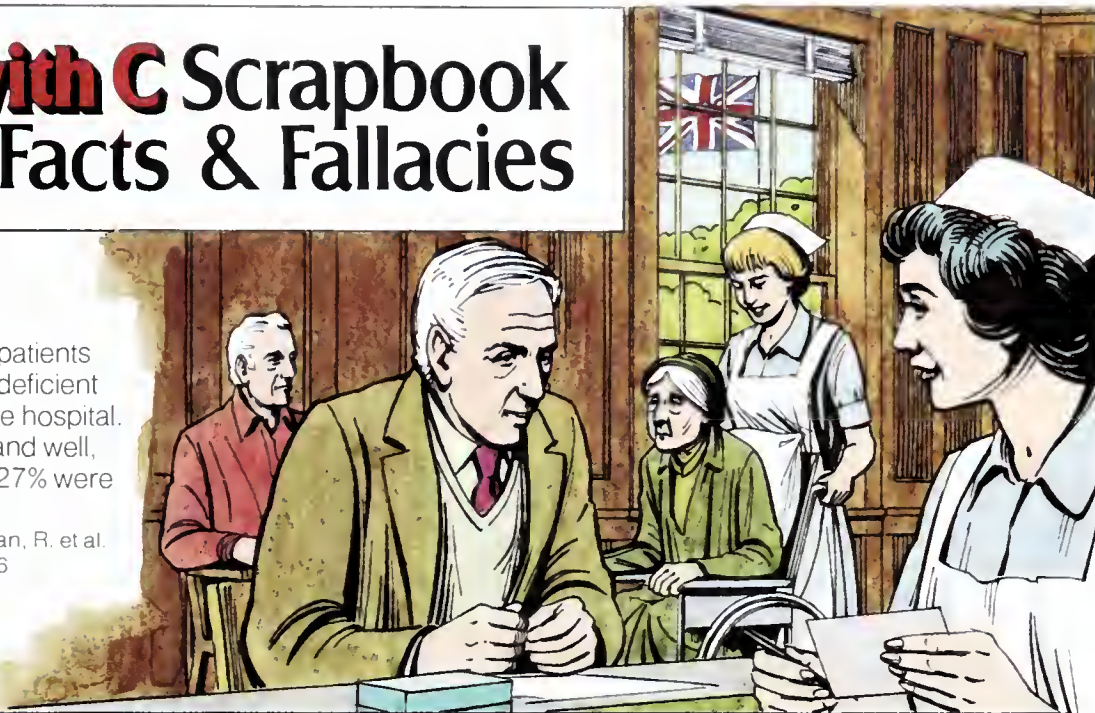
ACTION:

It was voted to seriously consider moving the HTR to the proposed Cancer Center building on the Queen's Medical Center grounds if and when there were acceptable guarantees, in writing, from the University of Hawaii administration and the Research Corporation of the University of Hawaii that the operational management, policy making, and final authority for release of all data from the Hawaii Tumor Registry continue to reside with the Cancer Commission of the Hawaii Medical Association. The HMA Council also voted that if the location of the Hawaii Tumor Registry within the proposed Cancer Center building thereby authorizes or makes possible the administration of the University of Hawaii or the administration of any other organization, including the Cancer Center, to supersede or countermand or avoid the decisions and policies of the Cancer Commission of

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Griffiths, L.L., Brocklehurst, J.C., MacLean, R. et al.
Diet in Old Age, Brit Med J. 1.739, 1966



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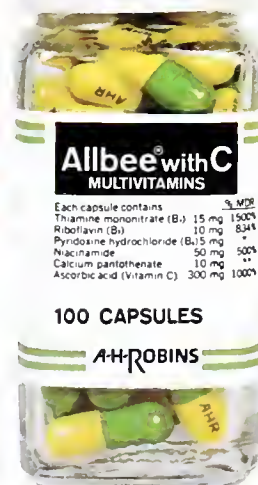
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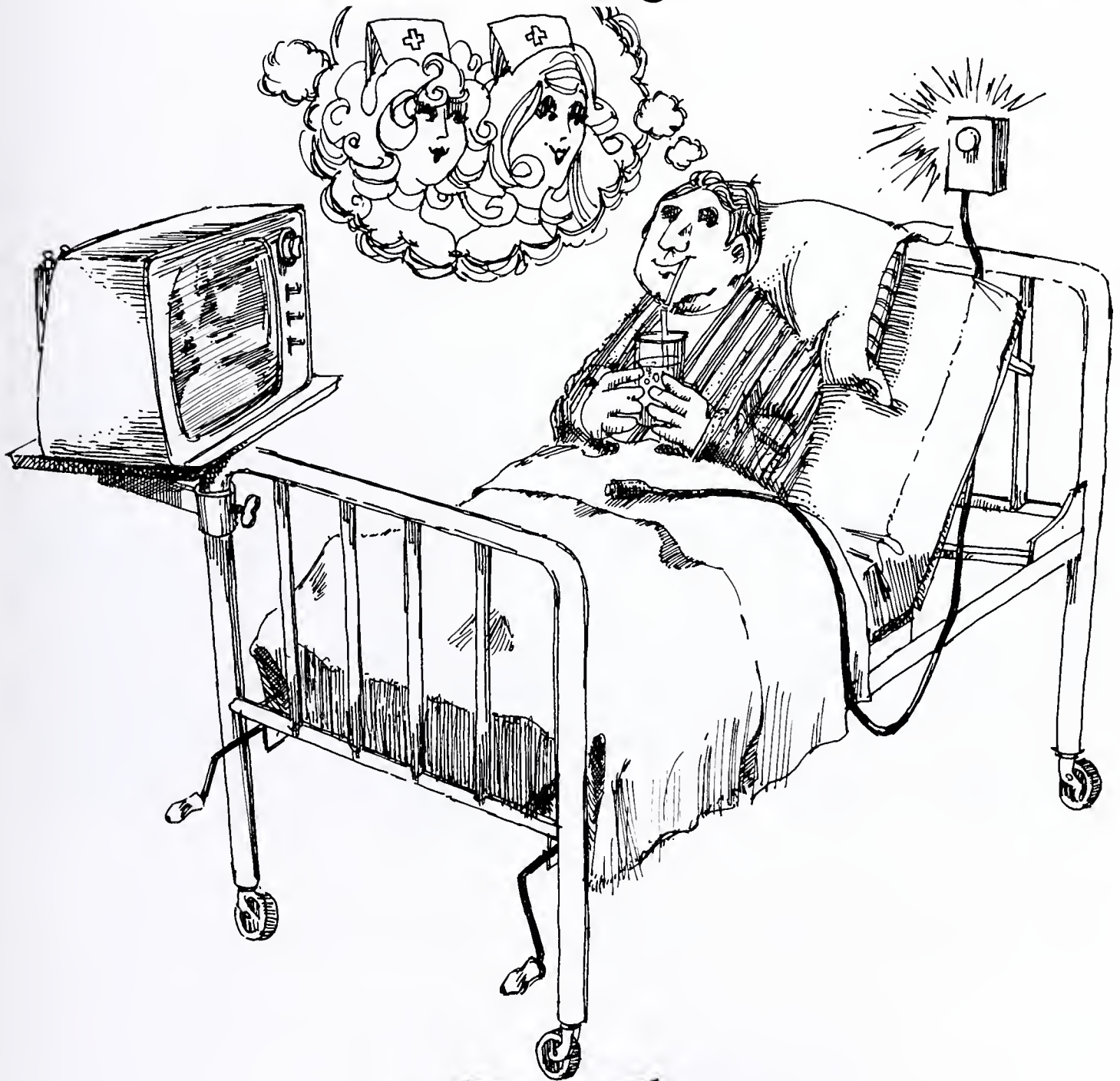
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the HMA, the HMA must respectfully remain unalterably opposed to such a move.

B. Community Health

Dr. Donald Char, chairman of the Community Health Committee, circulated the committee's reactions to the National Health Goals and Standards being developed under PL 93-641. The Council was asked to review the committee reactions and to phone in any comments to the HMA office within one week.

ACTION:

It was voted to submit the HMA Community Health Committee reactions to National Health Goals and Standards to SHPDA if there were no further comments within one week from members of the Council.

C. Reports of the County Medical Societies

Honolulu County: Dr. Ann Catts reported that the HCMS Board of Governors had decided to refund the 1977 dues of those members who had been dropped from membership for failure to contribute the minimum payment to the HMA building fund in 1976. The refunds will be prorated since members have enjoyed the benefits of membership for a portion of the year. It was recommended that the HMA Council consider refunding the HMA portion of the dues as well.

ACTION:

It was voted to refund the HMA dues, on a prorated basis, to those members who paid their 1977 membership dues but did not pay their 1976 contribution to the building fund.

Hawaii County: The Hawaii County Medical Society requested that the HMA begin negotiations immediately with the Veteran's Administration for a new contract and that this item be placed on the next Council meeting agenda. It was also recommended that the AMA be contacted and asked to send the *AM News* to all county medical society offices via first class mail.

Maui County: Maui County invited Dr. Sia as their guest speaker at the last MCMS meeting.

D. Mabel Smyth Building Suit

Mr. Rice reported that he had appeared in court on Tuesday, May 10 to represent the HMA in an injunction which had been filed regarding the Mabel Smyth Building against the HMA and Queen's Medical Center. The court appearance was a preliminary hearing and no further action had been taken since that time.

E. EMS

Attorney Rice reported that the HMA's Emergency Medical Service program has been sued by an EMS trainee who had been suspended from the training program. The details of the suit were reviewed.

ACTION:

It was voted to give Dr. Sia the authority to proceed to employ Dr. William Dang as EMS Project Director as of May 26, 1977 if Dr. Sia believed it necessary to do so.

ADJOURNMENT

The meeting adjourned at 10:15 p.m.

DOUGLAS B. BELL II, M.D.
Secretary



Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

New Members—AnnMarie Santos of the UHSM '81 has joined us as a new Student Member. The more of the fairer and gentler sex the better it will be for medicine. **E. Fred Schroeder MD, ABFP**, has been accepted as a new Active member. Welcome!

News of members—Students Denzer, Gilhooly and Shiraishi did yeoman service at the medical tent at the Third Kahalu'u Country Fair for two days 20 & 21 August. Active member **Ernest Bade MD**, Chief-of-Staff at the Hilo Hospital, made waves in newsprint on behalf of the medical staff in objecting to the 51% increase in hospital rates proposed by the State (SB 8/2/77). **Rod Miller** of Haleiwa was featured as a doctor who could say "No" to drug abusers, in the third of a series of articles by Harvey Meyerson (SB 8/11/77). Good picture, Rod, and a good article anent Family Practice. **Jim Grobe**, AAFP ex-President, attended the August USC-UH Annual Refresher Course in Waikiki and was snared by **Dave Swanson** to go talk to his Residents at THMC. Dave reported, incidentally, a 68 y/o woman patient he treated for serologically confirmed Rubella. The "Military" must be rather desperate for patients, these days!

Dropped—as members were **Doug Doyle**, Life Member, and **Patrick Lowry**, Resident Affiliate member, who resigned.

Condolences—from the Hawaii Chapter are being extended to Dorothy, the widow of **Ewart S. Sarvis**, MD Toronto University Medical School 1922, Life Member and a member of HAFP since March 1951, from Kailua-Kona. Ewart died earlier this summer. We received word from Hq in Kansas City.

Membership—as of 31 July 77 our membership stands at 131 total, of which 59 are Active, 7 are Active Exempt, 2 are Sustaining, 7 are Practicing Affiliate, 6 are Inactive, 12 are Life, 36 are Student Affiliate and 2 are Resident Affiliate.

ABFP news—Of the 11,080 ABFP diplomates, 9,067 are members of the AAFP. 95% of these AAFP members are in the Active category. This translates as 35% of the Active members of the AAFP are Board certified. Here in Hawaii we now have 22 diplomates who are Active members, or 37%.

CME . . CME . . CME . . ad nauseam!—The big one is coming up in Las Vegas October 10 through 13, to be followed by the Kailua/Kona Invitational. The latter is

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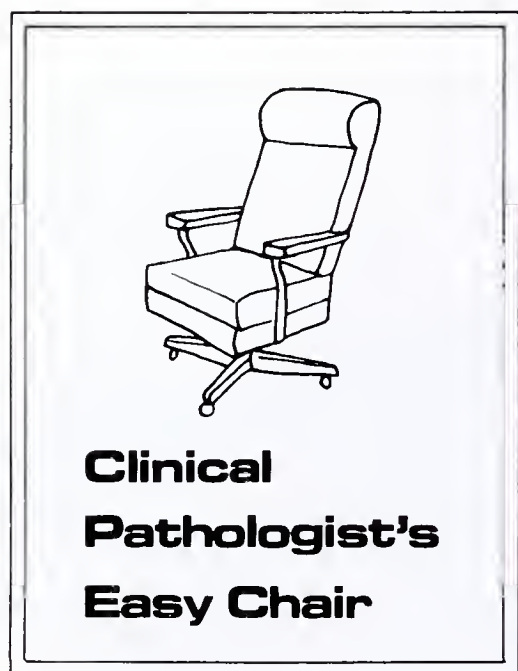
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good for 16 P. Any member planning to go to Las Vegas might like to go early and be an Alternate Delegate. The Congress meets at 8:00 AM Saturday 8 October. If interested, get in touch with **Pat Dietrich**, our Secretary, who must certify you as a delegate.

Annual Meeting—of the Hawaii Chapter will take place on 21 and 22 January '78.



FRANCIS FUKUNAGA, M.D.

Thyroid Function Tests

A "routine" battery of *in vitro* tests for thyroid function should assess the level of the thyroid hormones, thyroid-binding globulin (TBG) and thyroid stimulating hormone (TSH). The thyroid gland takes up iodine and tyrosine and manufactures the iodotyrosines and the hormones, T-3 (triiodothyronine) and T-4 (tetraiodothyronine or thyroxine). The manufacture and release of these hormones are stimulated by the TSH; increased blood levels of hormones depress the TSH secretion via a feedback mechanism.

The hormones are carried by the thyroid-binding proteins (predominantly TBG), but the metabolically active hormone is 'free' or unbound. The level of 'free' hormone depends upon a constant ratio of total hormone to TBG in the euthyroid individual. Should the TBG concentration increase, as in pregnancy, with estrogens, or oral contraceptives, the total hormone concentration also increases to maintain a normal concentration of 'free' hormone. The converse is true where the total hormone level decreases, when the TBG is reduced secondary to chronic illness or such medications as corticosteroids and dilantin. There are also genetic causes of increased or decreased TBG.

The TBG is normal in 95% of the population; the total hormone value will therefore correlate with the thyrometabolic status in these individuals.

The PBI is a measure of total circulating organic iodine, which includes the iodotyrosine as well as the thyroid hormone. This test is frequently abnormal, due to contamination by iodide-containing medications or x-ray contrast media. Thyroxine by the Murphy-Pattee radioassay is not subject to contamination and has largely replaced the PBI. T-4 by this method is subject to the vagaries of competitive protein binding and is not a very precise (reproducible)

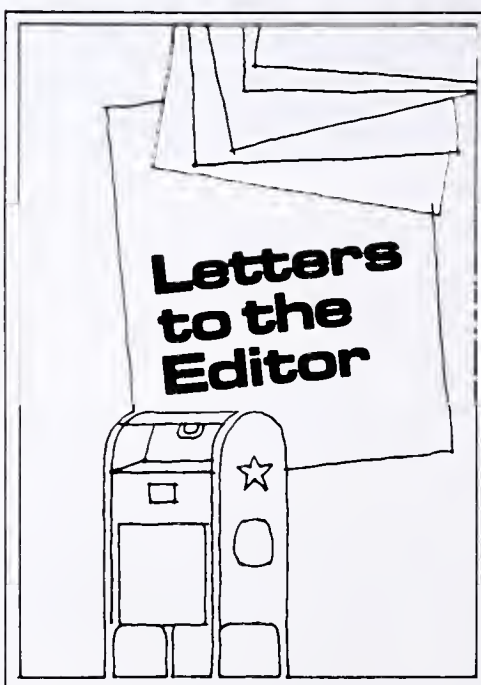
procedure. T-4 by radioimmunoassay is much more precise and is now the procedure of choice.

Since T-4 is the more abundant hormone, it was previously believed to be the more important thyroid hormone. However, it has been shown that T-3 is about five times more active than T-4; T-4 is largely a 'prohormone' that is converted peripherally to T-3. Therefore, T-3 by radioimmunoassay is theoretically the best single test for hyperthyroidism, since it will be elevated in Graves' disease and T-3 toxicosis.

The 'T-3 uptake' is an indirect assessment of TBG concentration. If the TBG is saturated, as in hyperthyroidism, the T-3 uptake by the resin is increased; conversely, if there are more binding sites available due to decreased thyroid hormones, the T-3 uptake by the resin will be reduced. There will be a falsely elevated T-3 uptake in pregnancy and other euthyroid conditions where TBG is increased, and falsely decreased T-3 uptake when the TBG is decreased. A better test for TBG concentration is by radioimmunoassay, but this is not yet a readily available procedure.

Although the 'free' or unbound hormone is the metabolically active portion of the thyroid secretion, the direct analysis of 'free' T-4 is too difficult and variable to be practical. A substitute method is the 'free T-4 index', a calculated value derived from the T-4 and T-3 uptake values. It was devised to compensate for abnormal values due to abnormal TBG concentrations. The compensated T-4 or Effective T-4 ratio (ETR) are modified Murphy-Pattee methods that compensate for the variation of TBG levels. Some consider the ETR or compensated T-4 the best single screening test for thyroid function, but the less than optimal precision of the Murphy-Pattee test should be kept in mind.

The best test for hypothyroidism is determination of the TSH concentration. The TSH is greatly increased in primary myxedema because there is no effective circulating thyroid hormone to depress the TSH secretion.



To The Editors:
HAWAII MEDICAL JOURNAL

I am writing regarding "Mandatory continuing medical education for licensure ... issuance of a **limited** license regulating ... fields of practice ..." in the State Medical Practice Act.

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Now I don't recall ever being polled in connection with the above two issues. Which brings up the question of whether the members of the House of Delegates consider themselves representatives sent into session to serve the membership, or whether they consider themselves our bosses.

If the outcome of the deliberations of the House of Delegates in this regard was not already a foregone conclusion, I would like the HMA membership to consider the following ideas in relation to the previously mentioned issues.

Mandatory continuing medical education for licensure—has anyone yet claimed to have a statistical study done recently in any of the States that already have mandatory continuing medical education that claims to show a significant drop in morbidity and mortality within that State since continuing medical education was made mandatory? And has there since been a corresponding increase in the longevity, and life expectancy of the citizenry of that State as a result? (If it turns out that imposing mandatory continuing medical education doesn't reduce overall morbidity and mortality, then what final good is it?) My contention is that an M.D. just automatically maintains his competence in those fields in which he has interest, far better than any Board would be able to plan, administer, and later, test. A doctor's own practice is also a powerful force that requires him to maintain his competence—as he would tend to lose competence, his practice will correspondingly decrease as well.

Continuing education as related to malpractice experience—my information is to the effect that the great bulk of malpractice claims is against the most highly skilled and trained members of the profession. We must disabuse our minds of the fond idea that it is the bungling, relatively uneducated doctor who draws the majority of all the suits: rather, the higher up the specialist echelon ladder, and the higher the degree of training a doctor has, the more likely he is to attract a malpractice suit. (I'm not suggesting we allow ourselves to get "rusty" so as to protect ourselves from malpractice but I fail to see how increasing our level of formal training will decrease the number of suits if the foregoing be true.)

Issuing limited licenses regulating the fields of practice of the licensee—I fail to see the desirability or need for it. With all the chances for the development of potential problems in this area, a doctor is still *his own best judge* of his competence in his fields of interest—far better than any politician or bureaucrat. (Not a perfect judge, just the best there is.) And to keep him honest as a judge is his practice, in helping him decide in what he will maintain his competence and in what he will not. Just for example, it's been some considerable time since I have decided to remove a craniopharyngioma in my office, under a local anesthetic, and it's been at least that long since it has occurred to anyone to ask me to do it either.

The issuing of limited licenses may appear somewhat logical in Honolulu, with tertiary echelon specialists warily watching each other so's no one will grab off a particularly juicy case for himself that someone else might feel he was more competent to treat and collect the fee for: but out here in the "sticks" of Kona it could be extremely inappropriate. I can practically hear myself on the phone right now, "How's that, ma'am? Your husband just collapsed on the bathroom floor, and he's blue, but still gasping? Yes, I'm the only Dr. on call at the hospital today, but those guys in Honolulu have limited my license, and I—how's that? He's bubbling at the mouth, now, and—say, ma'am—why don't you call one of those legislators or examining board members and maybe *he'll* come from Honolulu and treat your hubby's heart attack?

If it can be arranged, I would not object to this letter's being printed in the HAWAII MEDICAL JOURNAL—it would be interesting to see if there are others in no great hurry to be meekly rushed into putting our collective head in the noose. A noose is a noose, whether one's Medical Society builds it for him or whether one's politicians do it (at least in the latter event they can't laugh at us later for having done it to ourselves—and by *that* orifice too, yet).

One thing I'd really like to see is evidence of some group within our State Society regularly working to secure *more* professional freedom of action for the harried, hurried, and

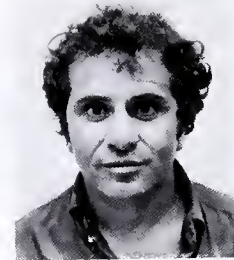
harassed M.D., instead of the continuing progressive imposition of restrictions, limitations, barriers, divisions, and penalties.

TRULY,
M. E. ROYCE, M.D.



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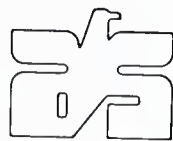
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Hawaii Medical Journal

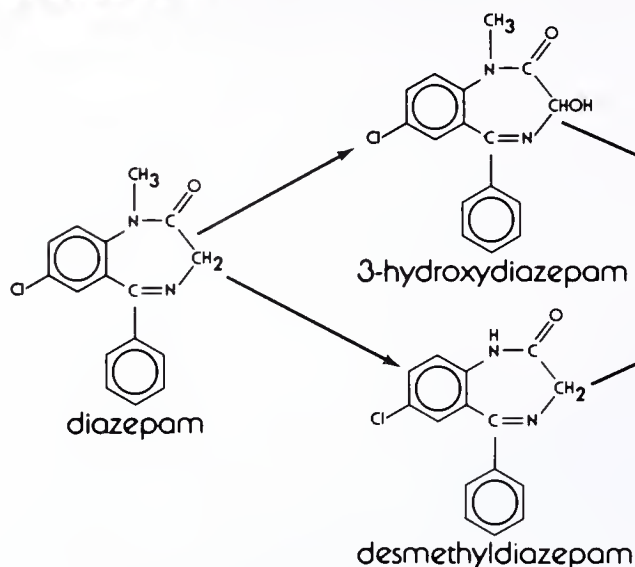
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memo

31

Monday
October
1977

NO APPOINTMENTS
THROUGH NOV. 4

(Opportunity to
earn over 20 hrs.
of CME credits in
AMA Cat. I Postgrad
Courses. Attend the
Combined AMA Regional
Mtg. & HMA Annual
Mtg. at the
Sheraton-Waikiki)

COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification
at His Home Without
Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony,
But Both Factions Are

WASHINGTON, Aug. 26, 1920—
struggle for wom-



Social Security Bill Is Signed; Gives Pensions to Aged, Jobs

Roosevelt Approves Message Intended to Benefit 30,000,000
Persons When States Adopt Cooperating Laws—He Calls
the Measure 'Cornerstone' of His Economic Program

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10,
1971—The Senate approved
today 94 to 0, and sent to

WASHINGTON, Aug. 14
The Social Security Bill, providing
a broad program of unemployment
insurance and old age pensions
and counted upon to benefit
20,000,000 persons, became law
today when it was signed by President
Roosevelt in the presence of
those chiefly responsible for
bringing it through Congress.

Mr. Roosevelt called the new law
"the cornerstone of my economic
program which is being built to
make the country complete
right to work."

TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain

"If we fail to use it," he declared
to the solemn final meeting of the
delegates, 'we shall betray all of
those who have died in order that
we might meet here in freedom and
safety to create it.'

"If we seek to use it selfishly—for
the advantage of any one nation or
any small group of nations—we
shall be equally guilty of that be-
trayal."

Fervent Interpolation

The President, speaking in the
auditorium of the War Memorial
Opera House, built in memory of
sons of the Golden Gate city who
gave their lives in the first World
War, in which he himself served,
seemed to give unconscious expres-
sion to the solemn feeling of the
occasion when, at the outset of his
speech, he interpolated the words,
half a hope, half a prayer:

"Oh, what a great day this can
be in history!"

the Draft Ends No

WASHINGTON, Jan. 27,
1973—"With the signing of
the peace agreement in
Paris today, and after re-
ceiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA

THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N.W., WASHINGTON, D.C. 20005



America's

*

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

“Possibly” Effective: For controlling bronchospastic disorders.

Final classification of the less than effective indication requires further investigation.

Contraindications: Because of the ephedrine, Marax is contraindicated in cardiovascular disease, hyperthyroidism, and hypertension. This drug is contraindicated in individuals who have shown hypersensitivity to the drug or its components. Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate to es-

tablish safety in early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy.

Precautions: Because of the ephedrine component this drug should be used with caution in elderly males or those with known prostatic hypertrophy.

The potentiating action of hydroxyzine, although mild, must be taken into consideration when the drug is used in conjunction with central nervous system depressants; and when other central nervous system depressants are administered concomitantly with hydroxyzine their dosage should be reduced.

Patients should be warned—because of the hydroxyzine component—of the possibility of drowsiness occurring and cautioned against driving a car or operating dangerous machinery while taking this drug.

Adverse Reactions: With large doses of ephedrine, excitation, tremulousness, insomnia, nervousness,

palpitation, tachycardia, precordial pain, cardiac arrhythmias, vertigo, dryness of the nose and throat, headache, sweating, and warmth may occur. Because ephedrine is a sympathomimetic agent some patients may develop vesical sphincter spasm and resultant urinary hesitation, and occasionally acute urinary retention. This should be borne in mind when administering preparations containing ephedrine to elderly males or those with known prostatic hypertrophy. At the recommended dose for Marax, a side effect occasionally reported is palpitation, and this can be controlled with dosage adjustment, additional amount of concurrently administered Atarax (hydroxyzine HCl) or discontinuation of the medication. When ephedrine is given three or more times daily patients may develop tolerance after several weeks of therapy. Theophylline when given on an empty stomach frequently causes gastric irritation accompanied by upper abdominal discomfort, nausea, and vomit-



No.1 air-line[†]

Marax[®]

TABLETS: ephedrine sulfate, 25 mg; theophylline, 130 mg; and Atarax[®] (hydroxyzine HCl), 10 mg.

MARAX[®]-DF SYRUP, per 5 ml: ephedrine sulfate, 6.25 mg; theophylline, 32.50 mg; Atarax[®] (hydroxyzine HCl), 2.5 mg; and ethyl alcohol, 5% v/v.

for bronchospastic disorders*
dependable • economical • convenient

Administration of the medication after meals will serve to minimize this side effect. Theophylline may cause diuresis and cardiac stimulation. The amount of Atarax (hydroxyzine HCl) present in Marax has not resulted in disturbing side effects. When used alone specifically as a tranquilizer in the normal dosage range (25 to 50 mg three or four times a day), side effects are infrequent; even at these higher doses, no serious side effects have been reported and confirmed to date. Those which do occasionally occur when Atarax (hydroxyzine HCl) is used alone are drowsiness, xerostomia and, at extremely high doses, involuntary motor activity, unsteadiness of gait, neuromuscular weakness, all of which may be controlled by reduction of the dosage or discontinuation of the medication. With the relatively low dose of Atarax (hydroxyzine HCl) in Marax, these effects are not likely to occur. In addition, the ataractic action of Atarax (hydroxyzine HCl) may modify the cardiac

stimulatory action of ephedrine, and concurrently, increasing the amount of Atarax (hydroxyzine HCl) may control or abolish this undesirable effect of ephedrine.

Dosage: The dosage of Marax should be adjusted according to the severity of complaints, and the patient's individual toleration.

Tablets: In general, an adult dose of 1 tablet, 2 to 4 times daily, should be sufficient. Some patients are controlled adequately with 1/2 to 1 tablet at bedtime. The time interval between doses should not be shorter than four hours. The dosage for children over 5 years of age and for adults who are sensitive to ephedrine, is one-half the usual adult dose. Clinical experience to date has been confined to ages above 5 years.

Syrup: The dose for children over 5 years of age is 1 teaspoon (5 ml), 3 to 4 times daily. Dosage for children 2 to 5 years of age is 1/2 to 1 teaspoon

(2.5–5 ml), 3 to 4 times daily. Not recommended for children under 2 years of age.

How Supplied: Marax Tablets are available as light blue, scored tablets in bottles of 100 and 500.

Marax-DF Syrup is available in pints as a colorless syrup free of all coal tar dyes, and should be dispensed in amber-colored bottles.

ROERIG *Pfizer*

A division of Pfizer Pharmaceuticals
New York, New York 10017

[†]The most frequently prescribed bronchodilator over the last few years has been Marax—based on market research data on file at Roerig/Pfizer.

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Ampoules, equivalent to 500 mg., 1 Gm.,
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Collaborative Team Approach to Non-Accidental Injury and Neglect in Children

GEORGE W. STARBUCK, M.D., *Honolulu*

● For over 4 years Honolulu's Children's Protective Services Center has been conducting "collaborative team conferences" of physicians, mental health and nursing specialists and social workers, to provide superior diagnostic and recommendations for treatment services in cases of "non-accidentally injured/neglected" (NAI/N) children. This collaborative team approach has proved an ideal multi-discipline training vehicle for physicians and other specialists desiring proficiency in NAI/N treatment. Our data shows that confirmed reabuse in team-handled cases recur less frequently than in non-teamed cases. The greatly improved climate of cooperation and communication among Honolulu's medical and social work professionals is another benefit attributed to the city's collaborative team program. Program development problems which occur in establishing a collaborative team effort are challenging, but can be minimized through careful management. Cost of the collaborative team approach to cases is not much greater than if there were no team.

Until the advent of antibiotics and new vaccines, pediatricians spent most of their professional time treating the many acute diseases that seriously threatened their patients.

Advances in treatment and prevention of acute diseases have freed more and more physicians to work on problems that, while related to medicine, are not wholly medical in nature. Working with non-accidentally injured/neglected (NAI/N) children* is one specialty area that has been receiving increasing attention in recent years.

In 1970 there were 6 or 7 multidisciplinary teams in existence. Now, they are more common,

their approach encompassing diagnosis, treatment and recommendations, or a combination of the three.^{1,2,3,4,5,6} In Kempe's lay therapy program, no reabuse has occurred when the child returned in 8 months or more. Kempe's cases were reviewed by a multidisciplinary team before return.

Physicians who seek to assist in NAI/N cases may find themselves hindered by their own inexperience in this field, and also may discover they have difficulty communicating with other involved para-professionals.

The social worker has traditionally shouldered responsibilities for "diagnosing and treating" children caught up in the NAI/N syndrome. Social workers' preeminence in child abuse work and the inability of physicians to provide substantial time and assistance with that work have resulted in a lack of ideal communication between these two groups.

Recognizing and dealing with this communication problem may be one of the most important goals pediatricians can pursue if they wish to play a more useful role in treating and helping NAI/N children. If best treatment is to occur, doctors and social workers have to find a way to use one another's expertise and experience more efficiently.

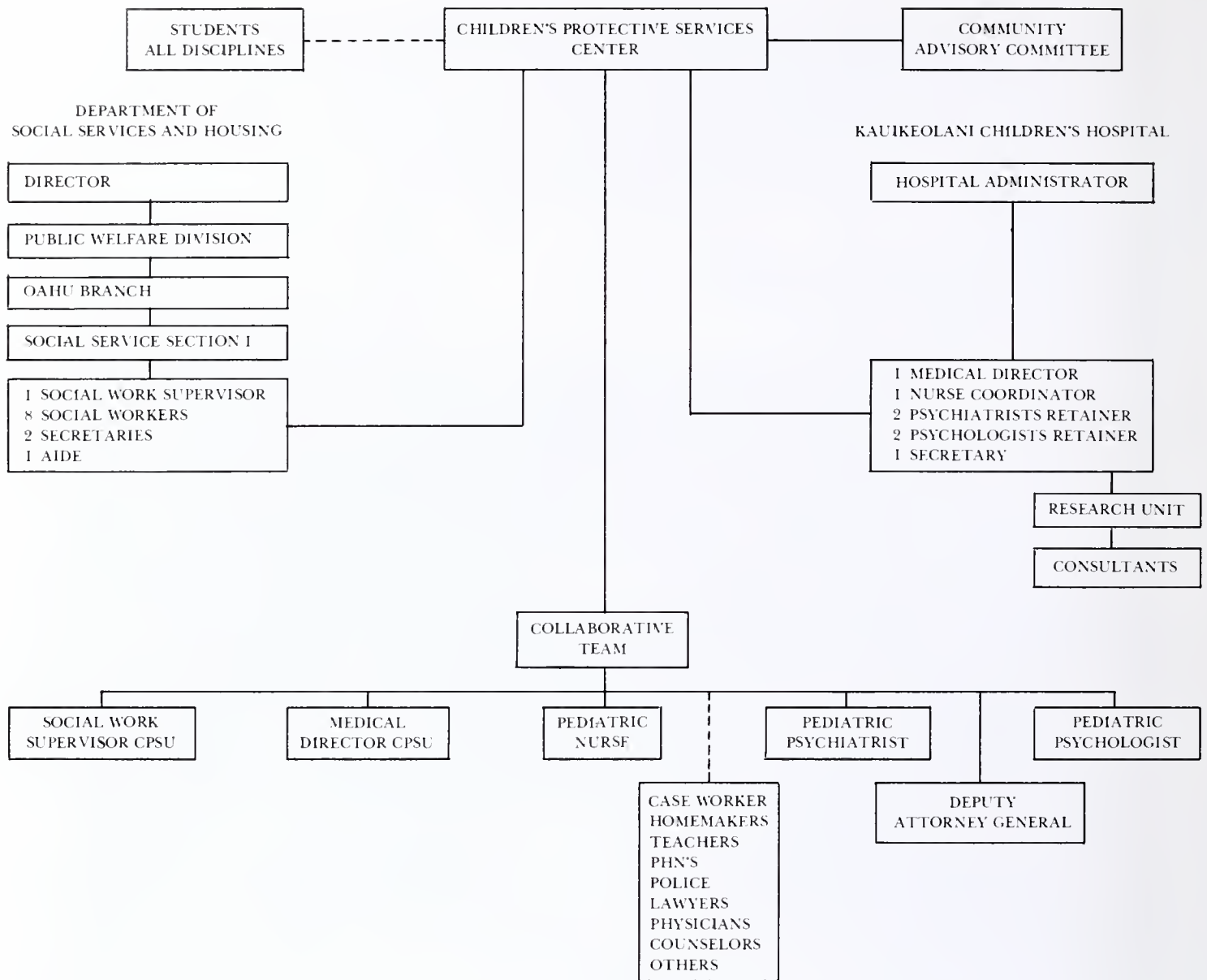
In the City and County of Honolulu, State of Hawaii, a unique application of the "collaborative team approach" to the diagnosis and treatment of NAI/N children is helping bridge the gap between doctors and social work professionals. "Teaming" selected cases of abused and neglected children has not only improved communications among professionals; it has also improved the outcome of treatment as evidenced by statistics.

Children's Protective Services Center, Kapiolani Children's Hospital, 226 North Kuakini Street, Honolulu, Hawaii 96817 and the Department of Pediatrics, University of Hawaii, School of Medicine. For reprints, write 226 North Kuakini St.

Accepted for publication September, 1976.

*Also known as "child-abuse" and the "Battered Child Syndrome."

FIG. 1



History of NAI/N Treatment in Honolulu

NAI/N child case treatment until recently involved only Hawaii state government agencies and private social work professionals.

In 1937, the Department of Public Welfare (DPW) was established to "protect children and prevent family breakdown in the Territory of Hawaii." Two decades later, the DPW, the Honolulu Juvenile Court, and the Honolulu Police Department developed "Operation Help," an outreach program designed to provide 24-hour social services to families in crisis.

The latter part of the 1960's brought major legislative and institutional developments to Honolulu's handling of NAI/N cases. In 1967, the State legislature broadened the law's interpretation of "child-abuse and neglect" to encompass physical, sexual, and emotional abuse as well as both physical and emotional neglect.

Increased reporting of cases and growing caseload volume resulting from these commendable changes soon led to a lag in the DPW's ability to service reported NAI/N cases adequately.

Late in 1969, the successor to the DPW, the Department of Social Services and Housing

(DSSH), used a newly expanded budget to increase the number of caseworkers assigned to NAI/N cases, to establish a Children's Protective Services Center (CPSC), and to provide for a NAI/N "collaborative team program" to work on selected cases within the new center.

Milieu for Collaborative Team: The CPSC

DSSH's Children's Protective Services Center (Figure 1) was founded and designed to "... protect the non-accidentally injured/neglected child, and diagnose, study and where possible treat both the child and the family." The establishing of Honolulu's CPSC was historic for the medical community because it was the first time in Hawaii that pediatricians and other physicians were included in a formal program designed to assist abused and neglected children.

Two functional components plus a community advisory group make up the CPSC. A social work supervisor, 8 on-the-job-trained case workers, plus case and secretarial assistants comprise one of these components, called the "Children's Protective Services Unit" (CPSU). This is the social-work arm of the Center.

The medical component of the CPSC consists of a full-time medical director (a pediatrician), a secretarial assistant, a part-time psychiatrist, a part-time psychologist, and a pediatric nurse, at Kauaikeolani Children's Hospital. The Center's medical staff works under a contract and budget negotiated annually between the State and the hospital. Social work and medical components are both housed in a single structure on the hospital grounds, enhancing the union between social work and medicine.

Kauaikeolani Children's Hospital maintains 24-hour telephone service during which time the Center provides social worker coverage. CPSC is the State agency mandated to receive reports on all cases involving NAI/N or suspected cases. The law states: "any person licensed by the State to render services in medicine, osteopathy, dentistry, or any of the other healing arts, examining, attending, or treating a minor, or any registered nurse, school teacher, social worker, or coroner acting in his official capacity, having reason to believe that such minor has had injury inflicted upon him as a result of abuse or neglect, shall promptly report the matter orally to the Department of Social Services; provided that when examination, attendance, or treatment with respect to the minor is pursuant to the performance of services as a member of the staff of a hospital or similar facility, the staff member shall immediately notify the person in charge of the medical facility, or his designated delegate, who shall report or cause reports to be made in accordance with this chapter." Everyone should be mandated to so report, but there should be no penalty for failure to do so.

When a report of child abuse is received by the CPSC, the information is assessed and, if appropriate, assigned to a case worker at the Center by the social worker supervisor. This case worker maintains personal responsibility for and jurisdiction over the child throughout the diagnosis and treatment process.

Kauaikeolani Children's Hospital provides a medical work-up on every NAI/N case admitted. The medical director of the Center and case social worker have direct access to the hospital medical staff, the hospital records and progress of the case at any time.

The medical director assists the social worker in obtaining medical information and reports from any hospital or physician, arranges for consultations, check-ups, and admission to the hospital if so indicated. Also, psychiatric and psychological workups are scheduled by the medical director after a medical clearance on a child has been completed. Normally, in "non-teamed" cases handled at the CPSC, the hospital medical staff has little or no sociological NAI/N followup involvement with the patient. A medical followup is done by the private physician or by the hospital Outpatient Department.

The case worker requests a team conference

which is then scheduled by the social work supervisor. The following criteria for conference have been established:

1. Severe abuse (see criteria for psychiatric consultation list)
2. Reabuse cases (all failures). (Exception: few bruises in child over age 5 on one or two occasions)
3. Cases requiring psychiatric consultation (see that list)
4. Cases requiring legal consultation (see that list)
5. Specific questions exist regarding diagnosis or treatment
6. Conflicting recommendations of different professionals or agencies
7. An unusual number of professionals and agencies involved in a multi-problem family situation
8. Evaluation of the safety of the home in cases of child abuse/neglect where foster care placement is being considered. (Note: This may require emergency teaming.)
9. Re-evaluation of the safety of the home in cases where child is in foster care and return is being considered
10. Educational cases

Not all social workers feel the need to "team" cases. The case load a worker carries plays some part in the decision to team or not to team. Overworked, tired social workers may find it onerous to write a long social summary in support of a request for a collaborative team conference and then attend, record and write up the results of the conference. If a petition to the court for custody is one of the team recommendations, this adds to the load of a person with the "tired worker syndrome." One reason a social worker may not seek help from the team is lack of self confidence, anxiety or fear of criticism regarding the way the case study was handled.

The Collaborative Team Approach

The collaborative team approach is implemented for a case at the Children's Protective Services Center or from other Honolulu social work agencies at the request of the individual case worker in charge, through the Center's social work supervisor.

A team conference, heart of the collaborative team approach, is a meeting of fixed team members plus additional professionals who may be interested in a particular case. The fixed team members are the CPSC social work supervisor, its medical director, attending psychiatrist and psychologist, pediatric nurse and legal counsel from the Attorney General's office. Social workers in charge of a case may invite others to participate, including involved school counselors, physicians, police, homemakers and lawyers. These individuals become members of the team for that case.

The informal, democratic atmosphere that prevails in team conference meetings permits free exchange of diagnostic and treatment opinions. This climate of easy communication helps team members develop recommendations which are the best possible combination of inputs from their differing disciplines.

The ideal team conference gives the team physician immediate personal access to all the professionals dealing with a specific NAI/N case. The physician is thus given a dual opportunity—to acquire greater knowledge of the complexities of NAI/N cases, and to provide, in person, necessary medical information.

This opportunity for direct contact in the multi-disciplinary problems inherent in NAI/N cases is producing a growing number of physicians and other professionals more competent in dealing with such cases.

In following the proven social work tradition of assigning final responsibility for each case to the individual case worker in charge, the agreed-on recommendations of each collaborative team conference are submitted to this case worker, who is free to use all, some or none of them.

Hopefully, team recommendations are prepared realistically and readily implemented. However, they still may not be carried out for various reasons. A recommendation may be made for court intervention, but the attorney may feel the case is weak and may advise against a court petition. The collaborative team, however, frequently feels cases should be presented to the judge in family court for the final decision regardless of the attorney's recommendation.

We are mandated to protect the child, and therefore recommend steps to carry out this mandate, which may need a judge's decision rather than an attorney's. The judge may rule against some or all of the recommendations in the petition. The team, at this point, is relieved of the responsibility of protecting the child, but has carried out its mandate. (Family court judges are appointed by the Governor, who confers with the Bar Association, Chief Justice and senior judge of family court.)

The degree of mutual cooperation and respect that exists among team members, and the practicality of team recommendations strongly influence how recommendations are accepted by the case worker in charge.

Development of the Collaborative Team Approach

The preceding description of a team conference, in which group professionals work together to create the optimum multidisciplinary recommendation, is, of course, the ideal situation. Team conferences cannot always approach this ideal, and those held in the early days of

Honolulu's collaborative team project often did not come close.

The CPSC medical director and other professionals involved in building up Honolulu's successful team conference environment faced many challenges and problems before achieving the successful program that exists today.

Most of the challenges in building a successful team program related to the communications barrier among doctors and between doctors and social workers. No mutually supportive group sessions could result spontaneously among varied professionals with a history of poor communications.

To bridge this communications gap was the initial responsibility of the Children's Protective Services medical director. Before the collaborative team could succeed, the medical director had to establish a good rapport with the local medical community and to prove his sincere respect for the problems and achievements of many individual case workers.

Initial efforts at bridging the lack of mutual knowledge and understanding between social workers and pediatricians meant that the medical director and staff physicians at Kapiolani Children's Hospital had to demonstrate their accessibility to CPSC case workers. Physicians had to learn as much about the economic, social and legal ramifications of the NAI/N child as possible, and they had to show they were able and eager to listen and help.

Gradually, case workers at the Center and at other social services units began to take advantage of the immediate availability of the full-time medical director, necessarily a sympathetic physician specially trained in acute and chronic physical and mental illnesses as well as in normal versus abnormal growth patterns. The same events took place when the Center employed a pediatric nurse. The Center's social work supervisor has always been the source of guidance, information, counsel and help to the case worker. She reviews cases before closing and sees all evaluation forms. These responsibilities are routine for all supervisors and are traditional in the field of social work.

As social workers and medical staff began to work together on both teamed and non-teamed CPSC cases, the work and communications environment improved.

Initial team conferences, with many members unfamiliar with the legal and practical bounds for treating NAI/N children, tended to produce recommendations that were "ideal," but which could not be implemented by case workers.

Several corrective measures were taken to improve team conference recommendations. A form was developed inquiring as to pertinent background information. A second form reports on the conference, summarizing important discussions, answers to worker's questions and team recommendations. A third form is a disposition

report, summarizing the case when it is ready for transfer to another unit. The fourth and final form is used for a 3-month follow-up report to the team and reporting agency and is repeated every 6 months until the case is closed.

Team conferences were scheduled at social services units away from the CPSC, so that all team members could get a first-hand look at field problems and those in the field could gain familiarity with team procedures. One team meeting a month was devoted to reporting followup and treatment results of completed team cases. Thanks to these corrective feedback measures, confidence in team recommendations improved. Inter-disciplinary contact, which gradually improved each professional's understanding of his associates' functional limitations, helped make team recommendations more realistic.

More realistic team recommendations and an improving environment at the CPSC for holding successful team conferences led to the next problem for the collaborative team program: too much demand on too little medical staff.

Originally, the medical director at the Children's Protective Services Center served as pediatrician for collaborative team conferences and retained a private-practice pediatric psychiatrist and a private-practice psychologist to serve him in their specialties.

The medical director, pediatric nurse, and two private-practice pediatric specialists make up the medical component of the team referred to as the "center team." This "center team"—medical consultants, pediatric nurse, social work supervisor for the CPSC, appropriate case worker, and other professionals still meets each week.

By the end of the second year (1971), the increased demand for team conferences made it necessary to hire, on a retainer basis, a second psychiatrist and a second psychologist for another team, referred to as the "resident team." Budgetary increases to cover the added cost were promptly granted by the DSSH. The psychiatrist and psychologist were chosen for this team from the salaried staff of Kauikeolani Children's Hospital Child Guidance Clinic. They received instructions in the special kinds of reports essential to cases, at the same time learning the intricacies of family dynamics common in the NAI/N cases. They acted as back-up members to the team, interpreting and discussing their own work-ups as well as those of others. They had a one-to-one relationship with the case worker, who was free to discuss problems and needs at any time. It was extremely helpful to have them readily accessible at the hospital guidance clinic.

This "resident" team, like the older "center team," meets twice weekly. Since all members of the resident team are normally at the hospital, emergency conferences can be convened quickly for crisis intervention in severe child NAI/N cases.

The medical director has numerous respon-

sibilities to the Center as well as to the team. He accumulates and organizes all diagnostic material including previous and current histories, physical exams, laboratory reports and X-rays. This review is distributed to team members as early as possible before the conference. He uses visual aids when available, interprets and gives advice pertinent to appropriate on-going medical care, and supports the suggestions of other team members, particularly in regard to mental health care, which is inseparable from physical care. A case worker consults with him on a day-to-day basis.

The psychiatrist and psychologist may evaluate any or all family members, interpret diagnostic work-ups, and interpret the involved dynamics of the case as an aid to the development of a treatment plan for the family.

The pediatric nurse prepares nursing summaries on cases, including those hospitalized. She interprets her findings and helps case workers if they wish to follow up on nursing needs through a public health nurse.

The attorney from the Attorney General's office acts as a counselor and evaluates findings for possible court action, interprets statutes as well as court orders, explains parents' and childrens' rights, and acts as DSSH attorney in all court cases.

The social work supervisor is the chairperson. After the case worker presents the case, she guides and participates in the discussion while organizing the final recommendations, obtaining opinion and direction from other team members.

Adequate legal consultation for the CPSC's team conferences was vital if the courts were to receive complete information from the collaborative standpoint. In the fourth year of team conference operations, the Attorney General's office assigned a Deputy Attorney for full-time participation in team conferences.

There are difficulties to overcome in establishing a collaborative team program for NAI/N cases, even with an "ideal" environment such as Honolulu's Children's Protective Services Center. However, Honolulu's team conference project, now in its fifth year, has produced gratifying accomplishments. Pediatricians, other physicians and social workers in the community are working more closely together in their treatment of children NAI/N injured and neglected. The results achieved are more comprehensive and successful than ever before. Table 1 shows the dramatic

TABLE 1.—Comparison of Team Utilization by Center & Non-Center Workers 1970-1974

	1970	1971	1972	1973	1974
Center Workers	13	32	52	36	51
Non-Center Workers	2	14	6	13	24
Percent of Utilization by Non-Center Workers	15.3	43.8	11.5	36.1	47

increase in team utilization by social workers from outside of the Center an increase of more than threefold from 15.3% in 1970 to 47% in 1974.

Cost vs Success of the Team Approach

DSSH spends approximately \$250,000 a year, including the KCH-DSSH budget, on children's protective services. This figure is an estimate of staff salaries at the CPSC, plus other costs such as rent. The State's contract and budget with Kauaikeolani Children's Hospital for all medical services provided by the full-time medical director and his staff specialists has increased annually.

The only solid figures that give some indication that the team approach may not cost much more than cases not teamed is to analyze the cost of the psychological and psychiatric portion of the team (Table 2). This budget does not include the cost of diagnostic workups nor of additional time spent by medical consultants of the Center preparing for and participating in team conferences.

TABLE 2.—Cost of Psychiatrist & Psychologist Per Hour and Case

	1970	1971	1972	1973	TOTAL
Psychiatrist Budget	\$3900	\$5000	\$5000	\$ 6000	\$19900
Psychologist Budget	\$2400	\$2700	\$4160	\$ 4500	\$13760
Total Cost (Both)	\$6300	\$2700	\$9160	\$10500	\$33600
Total Hours (Both)	200	200	200	200	800
Average Cost/Hr. (Both)	\$36.5	\$38.5	\$45.8	\$52.5	\$42.0
Total Cases Teamed					185
Cost Per Case					\$ 181

Because the teams are partly made up of professionals salaried by social service departments, it is impossible to fix a cost for the collaborative team conference program alone.

Four years of observation and administration of the team approach leads to the conclusion, however, that teaming does not cost significantly more than maintaining an adequately staffed CPSC operation. Table 2 bears this out.

The cost for these disciplines per hour and case compares favorably with the costs of a single day on a hospital ward for a child. In addition, these professionals include in their services their availability to discuss a case at any time with the

social worker, and to review hospital psychiatric records, school testing and all reports received from diagnostic work-ups. The rise in cost during 1972 and 1973 is attributed to increased charges for these disciplines both in private practice and at the Child Guidance Center, plus an annual increase in the number of cases brought to team (Table 3-See *).

Any community which is already spending substantial funds on protective services can also provide what is probably the most beneficial system—for physicians, social workers and the patient—in the handling of NAI/N cases: the collaborative team approach. Advance recognition and good management can help such a community minimize the pitfalls and problems experienced in the pilot Honolulu team project.

After 4 years of evolution, collaborative teaming at the CPSC in Honolulu is becoming a major success story. Many signs indicate this success.

Pediatricians and other physicians in the community have increased their referrals of suspected NAI/N cases to the CPSC and consult increasingly frequently with the medical director. Social workers in both governmental and private agencies have also increased their contact and consultations with the medical director.

Judges recognize the medical director of the CPSC as an "expert witness" in family court cases. Family courts have asked CPSC to bring cases of emotional abuse and deprivation for their opinion, feeling it is time to establish criteria for judgment on such cases, many of which are borderline.

Community professionals are increasingly participating in team conferences in which they have a case interest.

Most significant of all is the steady upward trend in the number of requests by case workers for team handling of NAI/N children. Table 3 shows statistics from CPSC files for 1970 through 1974. Of the total of 1610 confirmed cases handled without the collaborative team approach at the Center between 1970 and 1974, there was a reabuse rate (the same child reported to the Center and confirmed as a repeat NAI/N case) of 6.3 percent (Table 4). By contrast, of the 185 team-handled cases for the same period, only 4 confirmed reabuse cases occurred anywhere within the jurisdiction of the CPSC, for a repeat percentage of 2.1 percent. With further review, we hope

TABLE 3.—Collaborative Team Utilization at Children's Protective Services Center 1970-1973 (OAHU, HAWAII)

	1967	1968	1969	1970	1971	1972	1973	1970-73	1974
Reports of Abuse/Neglect	88	67	375	972	1015	1047	853	3758	859
Confirmed Abuse/Neglect	69	49	204	487	504	480	405	1795	50%
Use of Collaborative Team (cases)	0	0	0	16	47	62	60	185	
Percent Team Utilization*	0	0	0	3.4	10.3	13.4	14.8	10.7	
No Use of Collaborative Team (cases)	0	0	204	439	408	418	345	1610	
Percent No Team Utilization	0	0	100	96.6	89.7	87.0	85.2	89.3	

TABLE 4.—Comparison of Re-abuse in Confirmed Cases
Teamed or Not Teamed
1970-1973

	1970	1971	1972	1973		
Cases Teamed	16	47	62	60	185	
Cases Re-Abused	2	2			4	2.1%
Cases Not Teamed	433	378	406	348	1610	
Cases Re-Abused	12	24	31	35	102	6.3%

to show the severity of cases teamed, but this figure is evasive at this time. We are aware that all of the severe cases do not come to team.

Judging by these comparative repeat case statistics, it appears that in the Honolulu experience, the collaborative recommendations produced by team handling of NAI/N cases do have some measurable favorable results. These statistics point out that the non-teamed case is 3 times more vulnerable to confirmed reabuse than those teamed. The conclusiveness of this figure must await the accumulation of a larger pool of teamed cases.

Conclusion

1. The collaborative team approach can be duplicated anywhere without great additional cost to an existing child protective program.
2. The collaborative team approach can be modified to fill the needs at regional, state, county or local levels.
3. It is a vehicle for training professionals,

especially physicians, to handle better the functional legal and emotional complexities of NAI/N children.

4. Joining physicians and social workers under a single program of a Children's Protective Services Center is a good start for any community. But only in bringing all lay professionals together into the collaborative situation can optimum results for all participants, including the "battered child," be obtained.

5. More social workers outside of the Center seek use of the team after a concerned approach to their needs is undertaken.

6. Non-teamed cases of NAI/N are reabused three times more frequently than teamed cases.

The true test of this approach can only come after sufficient time has lapsed to make a long-term evaluation of these cases. Do these children reach their full potential in years to come? Is the perpetuation of NAI/N in succeeding years decreased so that the preventive aspects are truly demonstrated? In the meantime, application of the collaborative team conference program to a broad population is modality to reduce recidivism.

Recommendations

1. All confirmed cases of NAI/N with a second report should at time of intake, be considered for collaborative team assessment.
2. All cases NAI/N confirmed two or more times must have a collaborative team assessment.

REFERENCES

1. Helfer RE, Kempe CH: The Consortium—A Community Hospital Treatment Plan. Helfer, RE and Kempe, CH (eds.): *Helping the Battered Child and His Family*. Philadelphia: J. B. Lippincott, chap. 12, 1972.
2. Helfer RE: The Center for the Study of Abused and Neglected Children. Helfer, RE and Kempe, CH (eds.): *Helping the Battered Child and His Family*. Philadelphia: J. B. Lippincott, pp. 285-297, 1972.
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4. Barnes GB, Chason RS, Hertzberg LJ: Team Treatment for Abusive Families: Social Casework, pp. 600-611, December 1974.
5. Delnero H, Hopkins J, Drews K: The Medical Center Child Abuse Consultation Team. Helfer, RE and Kempe, CH (eds.): *Helping the Battered Child and His Family*. Philadelphia: J. B. Lippincott, chap. 11, 1972.
6. Newberger EH: Interdisciplinary Management of Child Abuse: Practical, Ethical and Programmatic Issues. Third National Symposium on Child Abuse of the American Humane Association, Charleston, South Carolina, October 1973.



BLEMISHES?

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Lydia O'Leary
OF HAWAII

ALA MOANA CENTER—STREET LEVEL

PHONE 949-3288



JON WON

The Auxiliary to the Honolulu County Medical Society will present its annual community service program Guest Day on November 17, 1977, at the Ala Moana Hotel Hibiscus Room. The Seminar, entitled "Society and Sexual Abuse," is open to the public. Registration will start at 8 a.m. and the Seminar will end at 4:30 p.m. The program will cover the sociological, medical, and legal aspects of rape involving women, men, and juvenile victims. Community resources for aiding the victims will also be discussed. This seminar, with speakers and panel discussions, has been approved for 8 credit hours for nurses. Audience participation will be encouraged during the question and answer period. The program will begin with a film, "Rape Culture," which is a documentary film that provides a look at the social forces in our culture that produce rape and rape victims. A charge of \$6.50 includes registration and lunch. Advance registrations are necessary and may be obtained by mailing a check for \$6.50 to Guest Day Program, HCMS Office, 320 Ward Ave., Suite 200, Honolulu, Hawaii 96814, or call 988-4267 or 395-4142 for more information. Deadline for reservations is November 8, 1977.

HMA's Group TDI Insurance Rate, we are happy to report, is dropping for 1978. HMA has been recently informed by the Industrial Indemnity Insurance Company of Hawaii that the experience of the HMA's Temporary Disability Insurance group has improved significantly during 1977. A 13% rate reduction is to be realized in 1978. Therefore, effective January 1, 1978, a rate of 67¢ per \$100 payroll will apply as opposed to our current 77¢ per \$100 payroll.

\$100,000 Group Life Insurance Program is now available to HMA physicians under an improved program. This new program now offers all of these important advantages:

- Amounts available up to \$100,000 (former program was limited to \$20,000 maximum coverage).
- Guaranteed issue (\$20,000 maximum through age 39; \$10,000 maximum ages 40 through 49) without evidence of insurability during Charter Enrollment period which ends November 30,

1977; and to new members of HMA who apply within 30 days of membership acceptance.

- Waiver of Premium, Accidental Death, and Dismemberment benefits automatically included.
- Spouse and children coverage optional.
- Low cost.

This Plan is being underwritten by Pacific Guardian Life Insurance Company of Honolulu, and all applications and inquiries should be directed to the Plan Administrator, Higuchi Insurance Agency, Inc., 1149 Bethel Street, Room 803, Honolulu, Hawaii 96813, telephone 531-7091.

HMA physicians have been mailed detailed information and an application form by separate letter.

HMA Annual Meeting, October 30-November 4, 1977, Sheraton-Waikiki Hotel. AMA Regional Seminar being held in conjunction with our Annual Meeting. HMA Annual Banquet and installation of officers on Friday night, November 4th. Dr. John Budd, President of the AMA, will be the installing officer. For those physicians that have not yet registered, time is late!

HAMPAC-AMPAC 1978 Membership campaign is off to an early start during the 121st annual meeting of the HMA. Physicians and their spouses who do not take advantage of this early membership enrollment have the opportunity to enroll at time of payment of their annual medical association dues. 1978 promises to be a year of increased political action by physicians. Your participation is needed.

DHEW Scheduled Hearings on national health insurance being held around the country, including Hawaii, to gather testimony by interested organizations and general public on a national health insurance program and its related issues. The Hawaii hearing was held on Wednesday, October 26, 1977, from 9:00 a.m. to 9:00 p.m., in the basement auditorium of the State Capitol. HMA was represented by George Mills, M.D. and Marion Hanlon, M.D., HMA President-Elect.

Those Physicians Who Wish To Serve the HMA on any committees or commissions or bureaus, please let the HMA office know. The new year for HMA is just around the corner, and President-elect Dr. Hanlon wants to know who is interested in what before making appointments. Physicians have received information on HMA's committees, commissions and bureaus with a return postcard to indicate your interest. If you haven't returned your card, please do so to be involved!

A Pilot Seminar was sponsored by the AMA on October 29, 1977, in Chicago, with the cooperation of the Television Awareness Training Program (TAT). This seminar focused on the television phenomenon—its effects, processes, and role in society. Psychiatrists, pediatricians, and family physicians attending the seminar were provided with current research on the impact of television on children and the family. Also emphasized was constructive means of using television programming as an outlet for parent-child discussions on modern social values.

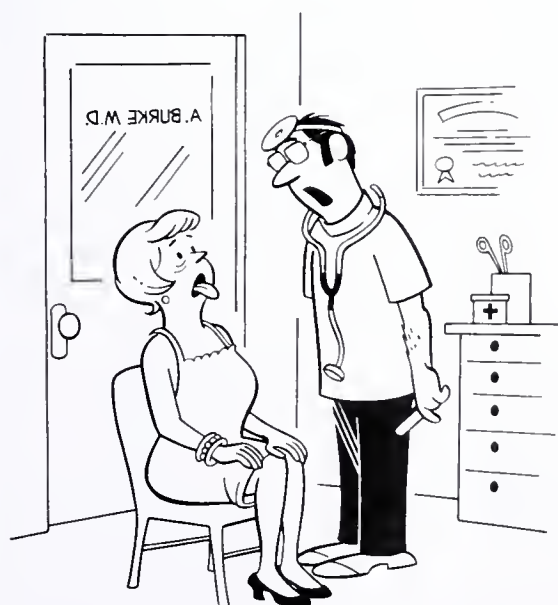
In-Hospital Indemnity Plan. During August HMA physicians were notified that the HCMS sponsored Major Medical Insurance Plan would be replaced on October 1, 1977 by the "IN-HOSPITAL INDEMNITY PLAN," underwritten by National Casualty Company. The Plan provides up to \$100 per day while confined in a hospital. During the initial enrollment period, August 1 to October 1, 1977, the normal age limit was extended from age 60 to age 65. Due to limited response during this period, the underwriters have extended enrollment time frame for this age group until November 30th, 1977. For complete details concerning coverages under this cash indemnity plan contact Higuchi Insurance Agency, Inc., 1149 Bethel Street, Room 803, Honolulu, Hawaii 96813, Phone 531-7091.

The AMA's Position That Forced Retirement at age 65 is detrimental to health was "instrumental" to passage of a bill to end mandatory retirement for most federal workers and raise the minimum age to 70 for non-federal workers.

A Second-Year Resident in Family Medicine from Rochester, New York, is interested in doing a one-month elective in Hawaii in a clinical setting. He will contribute his time without salary but would need living accommodations, food and transportation for himself and his wife. He is licensed in New York. Any interested physicians contact the HMA office for details.

Primary Care Center, hospital-based group practice recruiting two physicians, board certified/eligible family practitioners or internists. Outstanding opportunity to provide innovative health services with emphasis on preventive care. Contact Director of Primary Care, St. Francis Hospital, 2230 Liliha Street, Honolulu, Hawaii 96817, or call 547-6534.

Wanted Immediately—Hawaii licensed physician to work part-time in Acute Care/E.R. Dept. of large medical group in Honolulu. Interested physicians call 523-2311, Ext. 211.



"IT NEEDS A REST."



Extended Care

Times have indeed changed and one of the more obvious indicators of this is the presence of the Skilled Nursing Facility (SNF), be it of the Extended Care variety (ECF), the Intermediate Care Facility (ICF) or any other.

The intent of the Congress, when Medicare was codified in 1965, was to anticipate the rising costs of hospitalization that would follow Third Party payment in full (or nearly so) for the medical institutional care of all those aged 65 or above. It incorporated into the law limits to stay in acute care hospitals. It allowed, instead, a period of extended care in a less expensive facility, less costly because of the absence of laboratory and x-ray, and because of the lesser frequency of physician visits. It did continue the level of nursing care, however. (As an aside, Congress, by mandating a preliminary 3-day stay in acute care, upped the costs of entry into lower level institutions, in cases where all of the diagnostic tests and the trials of treatment had taken place previously.) Congress then limited the length of stay in ECF's, and restricted the qualifications for such care. It made no provision for the financing of the least costly of all: The usually prolonged stay in a nursing home.

As a natural consequence of this poorly thought out scheme (with almost no planning input from the medical profession), the ECF's rapidly became saturated with patients requiring long-term nursing care. The back-up into acute care hospitals became chronic and considerable and still continuing, as there existed no provision for the flow of traffic out the other end of the ECF's towards the nursing homes.

The government has tried ineffectually to resolve the bottleneck, **not** by financing the construction of and the running of care homes, but by instituting intermediate facilities of varying "levels of care."

Not only was this effort counterproductive because government rules and regs were too re-

strictive to attract private entrepreneurs to "venture" for dubious profit into the field, but it also was conducive to the development of every possible devious means to evade the intent of those regulations, and to pay only lip service (most Fedreg monitors accept documentation—if the latter is couched in bureaucratese—even though it has no direct relationship to actual occurrences or conditions in the case!). Builders/developers, as well as facility managers, played the adversary game vis-a-vis the government, under the modern ethic subscribed to by many within our society: All's fair in love and war and in dealing with the government!

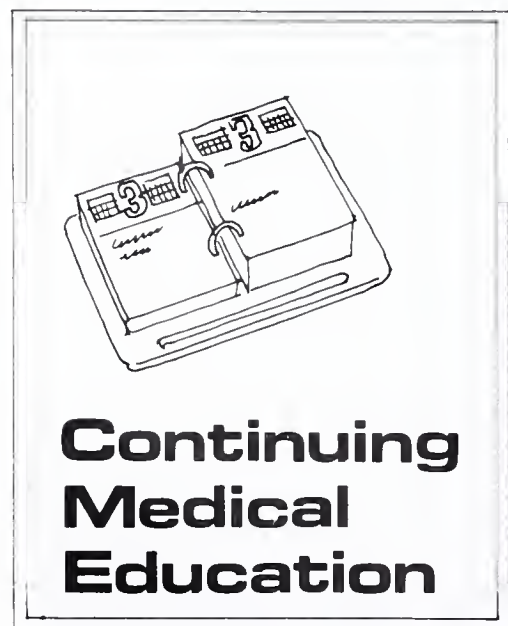
We say that once a patient is well enough **not** to require acute hospital care, every means at the disposal of our society should be directed towards settling him in suitable accommodations, with the greatest financial assist given to the least sophisticated level of care.

We should phase the physician out of the picture as much as possible. Let him be called to see the patient P.R.N., by the Registered Nurse on duty, who should be given and should be allowed to assume responsibility for the care of that patient.

The various extended care facilities should be "in loco parentis" until such time as the family can assume or resume care and responsibility, or until other permanent arrangements are made.

One of the large factors in increased costs of patient care in these institutions is the physician's being mandated to make un-needed visits and do a lot of paperwork that is duplicatory and unnecessary. This aspect of the government's rules and regs is demeaning of the nursing profession. The designation of these ECF's as "skilled nursing" facilities adds insult to injury. What "nurse" is unskilled?

JIFR



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

1. G.I. Conference, Oct. 29, 1:00 p.m.
2. Medical Mortality & Morbidity, 4th Tues., 1:00-2:00 p.m.
3. Endocrine Conf., 2nd Wed., 1:00-2:00 p.m.
4. Oncology Conf., Every Thurs., 7:30-8:30 a.m.
5. Surgical Conf., Every Fri., 1:00-2:00 p.m.
6. Surgical Mortality & Morbidity, 4th Fri., 1:00-2:00 p.m.

(Contact: CME Dept.-Kuakini for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
- Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
- Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
- Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
- Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
- Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
- Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
- Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
- Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
- Urology Grand Rounds, as designated
- Psychiatry CME Conference, as designated
- Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professors' Program.

St. Francis Hospital

1. Medical Grand Rounds, Tuesday (4th & 5th) 12:30-1:30 p.m. Sull. IV Classroom
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
7. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Honolulu County Medical Society and Local Hospitals, Honolulu

Type: I, 1 hr/day, 1 day/mo from 12 mos

Fee: None Methods: AV, O, Pan

Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

Type: I, 1 hr/day, 1 day/mo for 8 mos

Fee: None Methods: AV, Clin C, O, Pan, R

Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

- Nov. 22- Dec. 7- Dec. 14, 1977 "Advanced Trauma Life Support (ATLS) Trauma Lab Courses for emergency physicians." 1-6 P.M. Rm. C-208, 2nd Flr. Biomedical Bldg. Schl. of Med U of HI. Contact: J.K. Sims, M.D. EMS (808) 547-4471.
- Oct. 31, Nov. 4, 1977 HMA Annual Mtg.-AMA Regional. Sheraton-Waikiki, Honolulu, Contact: Mrs. Bess Chang -HMA 320 Ward Ave. S 200, Honolulu 96814 or (808) 536-7702.
- Oct. 31- Nov. 5, 1977 Visiting Prof. Prgm-HI Thoracic Soc. & Am. Lung Assoc. Major hsp on Oahu, Kauai, Maui & HI—6 days-6 hrs.

- Oct. 31- Dec. 6, 1977 Diving Med.-Univ. of HI Schl. of Med. 1960 E-West Rd. Honolulu, 96822. Held at King Kamehameha Htl. on Kailua-Kona. Fee \$225.
- Apr. 23-30, 1978 HI Thoracic Soc. Annual Mtg. Fireside Chat Conf. 7:30 p.m.-Oahu/Waialua Rms.-Sheraton Waikiki Htl. "Diagnostic Procedures in Lung Disease"-Speaker: Adam Wanner, M.D. "Tuberculosis in HI"-Panel.
- Nov. 1, 1977 American Academy of Neurological Surgery, Dr. John Lowrey, 888 So. King St., Honolulu, HI 96813. Hdq. Hotel: Mauna Kea Beach. Agent: Not appointed.
- Nov. 2-5, 1977 Cardiology Minicourse—Wahiawa Hsp. 12:30 p.m. 1 hr. each—CME Cat. 1. Contact: Noberto Baysa, M.D.—Wahiawa CME Dept for further info.
- Nov. 8-15, 22, 29, 1977 Comprehensive Laparoscopy: Current Principles & Practice, UCSD at Kona Kai Club, Kona, HI. Sat.-Mon.
- Nov. 12-14, 1977 Workshops High Risk Pregnancy: Infertility, UCSF at Royal Lahaina Htl., Maui, HI. One week.
- Nov. 12-19, 1977 Endocrinology & Fertility at Kauai Surf Htl., Kauai, HI. 3 days-12 hrs. U of Cal Extended Prgms in Med Educ, 3rd and Parnassus Ave. S.F. CA 94143.
- Nov. 13-15, 1977 Hyberbaric Med. Course-U of HI Schl. of Med. Held at Mabel Smvth Aud. Speaker: Eric Kindwall, M.D. 3 days-21 hrs. CME Cat. 1, 10:00a.m.-6:00p.m. Contact: Ed Beckman, M.D. (808) 948-8652 for further info.
- Nov. 15-16, 17, 1977 Lymphoproliferative Disorders, USC at Mauna Kea Beach Htl., Kamuela, HI. One week.
- Nov. 28- Dec. 2, 1977 "Ultrasound of the Eye and Orbit" Seminar. Waikiki Sheraton & Tripler AMC. Univ. of Iowa & Tripler. CME Cat. 1-21 credits. Contact: Philip M. Corboy, M.D. Co-ord. (808) 923-4734.
- Nov. 27, Dec. 2, 1977 ENG Workshop, Pacific Med. Cnts., San. Fran. Martin Brotman, M.D., Chairman. CME, P.O. Box 7999, San. Fran. 94120. Held at Ilikai Htl., Honolulu. Fri.-Sat.
- Dec. 1-5, 1977 Cardiology Seminar, Hawaii Conference Services, P.O. Box 22670, Honolulu, HI 96822. Hdq. Hotel: Mauna Kea Beach. Agent: Group Travel Unlimited
- Dec. 5-9, 1977 Amer. Med. Joggers Assn. 5th Annual Hono. Symposium. Princess Kaiulani Htl-Waikiki, HI. U of H Schl. of Med. & Hono. Med. Group, 550 So. Beretania St. 96813.
- Dec. 6-10, 1977 Fundamentals of Echocardiographic Interp. at Kauai Surf, Lihue, Kauai, HI. 5 days-20 hrs. Fee \$325 or non-members \$375. Amer Coll of Cardiology, 9111 Old Georgetown Rd. Bethesda, MD 20014/U of HI Schl. of Med. Hono Med. Grp.
- Jan. 9-13, 1978 Perinatal Med at Royal Lahaina Ht., Maui, HI. 5 days-30 hrs. U of So. Calif. 2025 Zonal Ave. LA, Calif 90033.
- Jan. 16-20, 1978 Gen. Pediatrics at Kona Surf Htl, Kona, HI 3 days-18 hrs. Amer. Acad OF Ped. 1801 Hinman Ave, Evanston, IL 60201.
- Jan. 12-14, 1978 3rd Annual HI Hsp. Med Staff Conf. at Kauai Surf Htl.-Kalapaki Beach. Estes Prk. Inst. Box 400, Englewood CO 80151. 5 days. Fee \$190.
- Jan. 25-31, 1978 Hsp. Trustee Forum at Kauai Surf Htl.-Kalapaki Beach. Estes Prk. Inst. Box 400, Englewood, CO 80151. 5 days-32 hrs. Fee \$190.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



Joseline G. Brestle, M.D.
ANESTHESIOLOGY

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Honolulu, Hawaii 96813



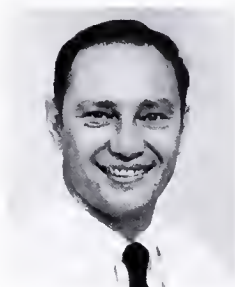
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MEDICAL GENETICS

1319 Punahou Street
Honolulu, Hawaii 96826



Masahiro Mori, M.D.
CARDIOLOGY

1697 Ala Moana Blvd.
Honolulu, Hawaii 96815



Andrew Sackett

State Department of Health
Hilo, HI 96720



Friday, July 8, 1977
HMA Conference Room

CALL TO ORDER

The meeting was called to order by President Calvin C. J. Sia. Also present were Drs. William W. L. Dang, Douglas B. Bell, Grover Batten, Marion Hanlon, George Mills, Herbert Y. H. Chinn, Ann Catts, Thatcher Magoun, Richard Lundborg, George Goto, J.I.F. Reppun, Leonard Howard, John W. Edwards, Sakae Uehara, Paul Condit for Albert Chun-Hoon, Roy Kuboyama for Calvin C. M. Kam, and William E. Iaconetti. Also present were Mrs. Fred Shepard and Attorney V. Thomas Rice.

MINUTES

The minutes of the May 25, 1977 meeting were approved as circulated.

REPORT OF THE TREASURER

The financial statement for May 1977 was reviewed in detail.

ACTION:

It was moved and seconded that the May 1977 financial statement be approved subject to audit.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. Public Health: Dr. Latta, chairman of the Communicable Disease Committee reported on the rubella epidemic. Guidelines for physicians regarding the epidemic were circulated and will be circulated to all physicians via the Department of Health Green Sheet. It was noted that it is especially important for the Department of Health to work closely with the Communicable Disease Committee of HMA prior to the establishment of rubella clinics and news releases.

ACTION:

It was moved and seconded to support the recommendation of the Communicable Disease Committee that until further information is forthcoming, physicians should continue with the present policy of not immunizing pregnant women with live rubella virus.

Both the Cancer Committee and Community Health Committee reviewed the request from Queen's Medical Center for a certificate of need proposal for the acquisition of a high-energy radiation therapy device and new Radiation Therapy Facility at QMC. The committees recommend Council support for the QMC request.

ACTION:

It was moved and seconded to support the acquisition of a high-energy radiation therapy device and new radiation therapy facility at the Queen's Medical Center. The motion was passed unanimously.

B. Report on the AMA Meeting in San Francisco: Dr. Sia reported that the reception held for Dr. George H. Mills was a success. He asked Dr. Ann Catts to present a carnation lei to Dr. Mills congratulating him on his election for a three-year term to the AMA Board of Trustees. Dr. Mills thanked the Council for their support and noted that he was very grateful for all the assistance that was given him during his campaign. He noted that he must resign as HMA's delegate to the AMA in accordance with the AMA bylaws and will thus leave the Council after serving 18 years as a voting member.

ACTION:

It was moved and seconded that the Council present a resolution to the House of Delegates resolving that any HMA member elected as an official of the AMA be automatically an ex-officio member of the HMA Council and HMA House of Delegates. The motion passed unanimously.

Dr. Sia noted that at the 1976 House of Delegates meeting, Dr. Iaconetti had received the majority of votes for first alternate delegate to the AMA in the event HMA was entitled to be represented by two delegates. It was therefore recommended that Alternate Delegate Herbert Chinn become AMA Delegate and William Iaconetti become Alternate Delegate.

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ACTION:

It was moved and seconded that the Council accept the resignation of George H. Mills as AMA Delegate, that Herbert Chinn be appointed as AMA Delegate, and William Iaconetti be appointed as Alternate Delegate. The motion was passed unanimously.

Dr. Mills presented some of the highlights of the AMA Annual Meeting which included national health insurance, euthanasia, expert witness guidelines, rotating intern and residency programs, saccharin, laetrile, RVS, school health screening, etc. A complete copy of the report will be presented to the HMA House of Delegates.

C. Report of the Auxiliary: Mrs. Shepard reported that the Auxiliary is currently assessing its role and questioning what might be done to get more members involved and how the Auxiliary might respond to its members. They have received an 18 per cent response to a questionnaire mailed to all members which listed many new ideas and concepts which they plan to try during the coming year. They hope to encourage the neighbor island members to attend more meetings by offering them overnight housing and assisting with plane fares.

D. AMPAC: Dr. Mills noted that he was honored to receive an AMPAC leadership award at the AMA Meeting. The award was presented in recognition of the participation of the entire Hawaii delegation as sustaining members of AMPAC. Dr. Leonard Howard, President of HAMPAC, received the award which will be framed and placed in the HMA Executive Offices.

E. Cancer Center of Hawaii: Dr. Sia reviewed the background of the Cancer Center discussions over the past three months. He noted that many meetings have been held with regard to the Executive Committee of the Cancer Center, the CBCCP program, and the Core Grant for the Center, as well as the allocated office space proposed for the Hawaii Tumor Registry in the Cancer Center Building to be erected on the grounds of Queen's Medical Center in the next few years. The concerns of the HMA as well as other community representatives were presented at each Council meeting and on May 6 the HMA Council voted to inform Dr. Matsuda that the Hawaii Tumor Registry would not be moved to the proposed CCH building. In view of the letter, Dr. Sia and Mr. Won were invited to meet with NCI site visitors who expressed concern that the total grant for the CCH would be given, in their opinion, very low priority based on the HMA letter of May 6. They asked the HMA to meet with Dr. Matsuda and other community agencies and discuss the matter and if they did not receive a response by July 1, 1977, the letter of May 6 would stand. A special Council meeting was called for May 25 and various representatives from the University, Cancer Center, Cancer Society, Department of Health and other interested persons were invited for the open forum. In the executive session of the meeting, the Council voted to incorporate the HTR and to notify Dr. Matsuda that the HMA would seriously consider moving the HTR to the Cancer Center Building if and when there were certain guarantees and assurances in writing. After the corporate papers were prepared, a letter was directed to Dr. Matsuda on June 13 stating the action of the Council. Dr. Matsuda responded on June 24 giving the assurances requested by the Council and stating that the operational management, policy making, and final

authority for release of all data from the Hawaii Tumor Registry would remain with the Cancer Commission of the HMA. Dr. Matsuda was again contacted by Dr. Sia and asked to reaffirm the agreements reached by the University, the Research Corporation and the HMA regarding the role of the Cancer Center Executive Committee. He did reaffirm the principles outlined in his July 31, 1974 letter to Dr. Frissell in a letter to Dr. Sia dated June 28, 1977. In view of the response from Dr. Matsuda as well as the July 1 deadline, it was determined that a telephone poll of the Council would be conducted and if a majority favored the move, a letter would be written to Dr. Matsuda. A telephone poll was conducted, a majority responded in favor of the move, and a letter was sent to Dr. Matsuda on June 29, 1977 stating that based on the statements contained in his letters to the HMA, the Council was polled by telephone and a majority of the members voted to move the Hawaii Tumor Registry to the Cancer Center Building on the Queen's Medical Center grounds. Dr. Sia asked that the Council formally ratify the letter of June 29 as the official stand of the Association.

In the following discussion, members of the Council noted their concerns regarding the conduction of telephone polls on issues of this nature, concerns regarding the imposed deadline for response of July 1, the legality of the assurances given by Dr. Matsuda, etc.

ACTION:

It was moved and seconded that Dr. Sia's letter to Dr. Matsuda of June 29 be ratified by the Council. A roll call vote was requested. The vote was as follows: Voting Yes were Drs. Sia, Hanlon, Catts, Lundborg, Goto, Reppun, Howard, Uehara, and Kuboyama. Voting No were Drs. Dang, Bell, Batten, Chinn, Magoun, Condit, and Iaconetti. The motion was carried 9 in favor and 7 opposed.

F. Professional Liability Insurance: The HMA was informed that Argonaut Insurance Company would increase premiums by 13.4% for professional liability insurance, effective July 1, 1977. It was also noted that a public hearing on the regulations for the Patient's Compensation Fund have been scheduled for June 29 and that levels of desired coverage can be obtained which range from 12% to 30% of the premium paid. It was also announced that the Hospital Association of Hawaii are going ahead with their plans for self-insurance.

ACTION:

In view of legislative amendments to Act 219 (1976 SLH) which eliminated the mandatory insurance requirements for licensure, a motion was made, seconded, and passed that the President instruct HMA Attorney V. Thomas Rice to discontinue HMA's suit against the State.

G. EMS: It was announced that Dr. William Dang assumed the role of project director for the EMS Program on July 1 and is leaving his position as Assistant to the President of the HMA. Dr. Sia asked Council to consider the appointment of Dr. Livingston Wong as chairman of the HMA-EMS Executive Board.

ACTION:

It was moved and seconded that Dr. Livingston Wong be appointed chairman of the HMA-EMS Executive Committee. The Motion carried and the president was instructed to express a vote of thanks to Dr. Wong for the time he spent as project director of the EMS Program.

H. Building Committee: It was reported that all space in the building at 320 Ward has been leased, and that the HMA would expand its operations into another area of the building. Some of the major expenditures were reviewed in detail.

I. Mabel Smyth Building: Attorney Rice reported that a countersuit had been filed in regard to the Mabel Smyth Building. It was noted that there is some indication that a settlement may be possible if certain conditions regarding the Board of Management of the Building are met. The Council instructed Attorney Rice that whatever might be agreed by the Queen's Medical Center and the Hawaii Nurses Association would be acceptable to the HMA insofar as it releases the HMA from the tri-party agreement for operation of the building.

J. County Society Reports: Dr. Lundborg reported on the activities of the Hawaii County Society and raised some questions regarding the right of the county societies to retain members who have been dropped from the HMA for failure to pay dues or assessments. Attorney Rice asked for some time to review the various bylaws prior to answering this question. It was also recommended that the HMA Bylaws be reviewed to allow county societies who believe they are unable to review various cases to be able to refer to the HMA Peer Review Committee. Mr. Rice will review the bylaws regarding this matter.

Dr. Ann Catts reported that the Honolulu County Society has scheduled a special membership meeting for September 13 which is open to all members as well as non-members. The meeting will focus on the benefits of membership, the plans for the future, criticisms of organized membership, etc.

ADJOURNMENT

The meeting adjourned at 10:15 p.m.

DOUGLAS B. BELL II, M.D.
Secretary



Hawaii Academy of Family Physicians' Newsletter

J. L. FREDERICK REPPUN, M.D.

New Members—David Hannan MD is a new Resident/Affiliate member working at TAMC and Victor Yano, UHSM'78 is a new Student member. Welcome to both!

News of Members—Student member Nan Morioka, UHSM'81 is also working for her Masters in Public Health and in a third endeavor has found her-

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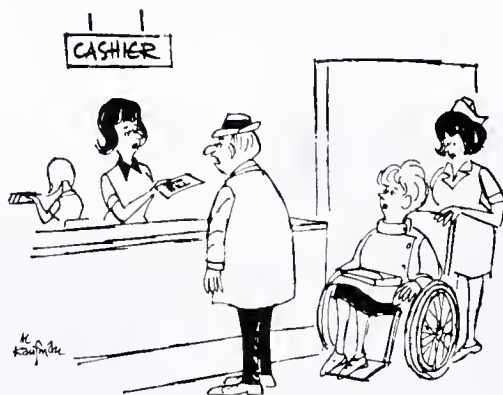
self a preceptor in order to gain some clinical experience. **Mary "Kit" Glover** is now in solo practice in Aiea.

Dues—The Council voted to keep local dues as they are, ie, no increase: Active \$20, Sustaining \$20, Practicing Affiliate \$15, Resident Affiliate \$10, Inactive \$5, Life \$5, Student Affiliate \$5. We understand, however, that national AAFP dues are to go up by \$25 for 1978! That means an Active member, on renewal, will have to pay \$120. This will have to be approved by the Congress of Delegates by 10 October.

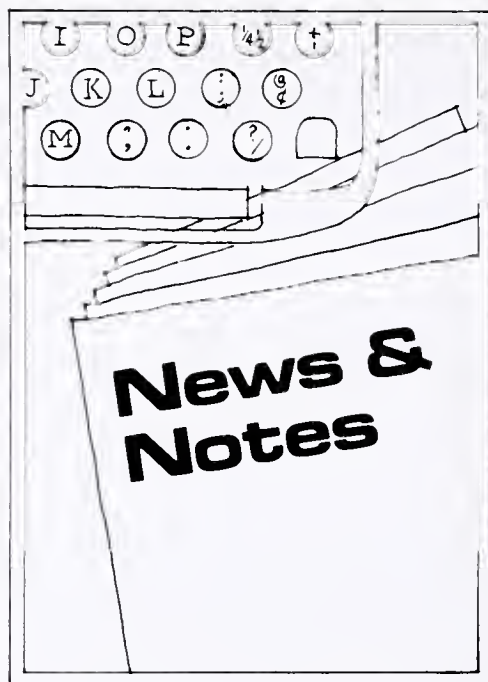
September Dinner Meeting—on the 17th at **Tom Cahill's** home up above Aiea and looking down on Pearl Harbor and the Aloha Stadium, was attended by 19 members and a total of 48 including guests. Ben Young MD, Psychiatrist at the UH Medical School presented Hokule'a, on which he served on the trip back from Tahiti, giving an account of the human relationship problems incurred. Carl Weisbrod, Psychologist, with his two assistants from the Honolulu Weight Control Clinic, Sally Walton and Margo Crabtree, gave a compelling demonstration of group hypnosis, **Fred Dodge** of Waianae and **Don Newman** of Molokai "going under" beautifully.

C.M.E.—The Hawaii Thoracic Society has sent out its pre-HMA program with P credits "pending" on an hour-for-hour basis. Adam Wanner MD is the featured speaker, from the Miami School of Medicine. He will be lecturing on Kauai on Monday 31 October, Tuesday noon at Wahiawa, that evening at the annual fireside conference at the Sheraton-Waikiki, Wednesday at Kaiser in the morning, St. Francis at noon, Thursday morning at Castle, Friday twice on Maui, and Saturday in Hilo. HMA plenary scientific sessions begin on 31 October, together with AMA Regional CME courses, continue through Friday 4 November, but we find no indication that any of these will be AAFP "P".

Annual Meeting—It is now definite! Saturday 21 Jan. 78 will feature an all-day session on "Teaching Skills" that should be of particular interest to preceptors and UHSM faculty. It will be held at the Kaiser Hospital auditorium. Lunch will be on your own at neighborhood eateries. Four Mainland faculty will stay over Sunday in order to present a scientific session in the morning on "Where Family Practice Stands Today," "Child Abuse," "Office Gynecology" and "Physiologic Changes of Aging." Saturday credits count for 4½ P; Sunday for 4 P. Registration for the 2-day package will cost members \$25, non-members \$35, Residents \$10 and Students nothing. Saturday night we will have our usual annual dinner and election of officers with their installation by an officer of AAFP, site to be determined.



"Aren't you going to give me something to kill the pain first?"



HENRY N. YOKOYAMA, M.D.

Sportsmen

Our venerable editor and elite horseman, **Harry Arnold Jr.**, was galloping along Mokuleia on his favorite, but skittish mount when a mongoose scurried across . . . Harry usually pulls up on the reins since he was thrown once by the same animal (fortunately, he had landed on soft sand and escaped injury). But the horse continued his even stride, seemingly oblivious to the intruder and Harry unfortunately relaxed . . . Two full gallops later, the horse had a delayed reaction and made an abrupt turn. Harry was thrown resoundingly and suffered an intertrochanteric fracture. Fortunately he is mending well and should be back at work in another month . . . (As told by **Fred Gilbert**)

Norobu Akagi, Hawaii's kendo expert extraordinaire, journeyed to Kyoto in May where he participated successfully in the international promotional tournaments and gained a coveted 7th rank.

Modest **Kazushi Tanaka** is our Go (Japanese chess) expert and maintains a 5th rank.

Quiet, unassuming **Paul Stevens** of Molokai won the first Annual Sheraton Molokai-Kailua Koa Invitational Golf Tournament on Sept. 25. Paul posted net rounds of 62-72 for a 134 . . .

Life In these Parts

"Sign in Ewa Beach doctor's office: 'You ask me for credit. I no give, you mad!! I give credit. You no pay, me mad!! Mo better all have understanding, then can be long time happy friends. Tanks, eh?' " (Gleaned from Dave Donnelly's column . . . "Nothing like straight talk from your doctor, right?")

A first . . . We've had our tennis elbows, but **Clarence McDanal**, Honolulu psychiatrist and surfer, described a surfer's elbow in a recent issue of this Journal . . .

We've had 3 separate incidents of needle fish (*Strongylura gigantea* or Auau) injuries in recent months. The most recent was that of a 10 year old Kauai boy who was sitting in his father's motor boat and was struck on his left eye by a three- or four-footer . . . He never recovered consciousness and later died at Straub . . .

With the increasing popularity of the CAT head scanner at Queen's Medical Center, St. Francis, Children's and Tripler hospitals have each ordered full body scans which cost \$800,000. After much pleading, Straub Hospital which sends at least 12 patients to Queen's a week has been conditionally certified by SHPDA (State Health Planning and Development Agency) for a \$500,000 head scanner. To further confuse the issue, a San Francisco inventor Dee Bradford has been proposing a mobile full body scanner which could be rotated between the different hospitals on time shared basis and thus reduce the cost from \$200 per scan to \$100 . . .

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Steven Strong of Lahaina has cited an increasing number of Mo-ped injuries and deaths esp. among tourists . . . Mo-ped riders are not required to wear protective gear or even acquire a license . . . The Maui police chief wants a bill to prohibit Mo-peds on public roads, but the Maui County Council met and did not take any action . . .

The *Advertiser* still chafing from months of difficulty getting information from Federal authorities under the Freedom of Information Act is recommending a U.S. Senate committee investigation in the Hale Nani Nursing Home fraud even though the former owner has paid back \$400,000 to Medicare and the statute of limitations has run out. The U.S. Justice Department has ended its investigation and had concluded that prosecution was unnecessary . . .

Fred Gilbert, breast cancer detection project director, reported that 112 breast cancers were detected among the 10,000 women examined in the past 3 years. Half the cases were detected by mammography. Fred feels that the cost and radiation are two concerns about the practicality of mammography in mass screening . . .

The World Psychiatry Association which met in Honolulu passed a resolution condemning the abuse of psychiatry for political purposes by a vote of 90 to 88. Needless to say, the Soviet psychiatrists were angered . . .

The Laetrile issue . . . Robert Young, top medical officer of the FDA, testified at a State Senate Health Committee hearing, "You can't find one trained scientist who is an expert on cancer treatment who will endorse Laetrile." Opposing Bob was another Bob. Robert Anderson, a self-taught nutritionist, bristled at and disputed virtually everything Dr. Young said. Anderson said, "To have bureaucrats tell us we can't eat food to protect us from cancer is the height of idiocy . . ." Young maintained, "To choose Laetrile is to choose suicide . . ."

The Hawaii Heart Study team of **Katsuhiko Yano**, **George Rhoads**, and **Abraham Kagan** reported to the 6th Asian Pacific Congress of Cardiology meeting in Honolulu that moderate drinking of 4-6 beers per day (judicious tipping) apparently reduces the chance of heart attack. The team also reported that coffee drinking does not affect heart disease risk as long as the coffee drinker does not smoke . . . Non-alcohol drinkers had a heart disease rate of 46/1000 persons while those drinking 4-6 beers per day had a rate of 21.2 per 1000. Beer appears to be safer than wine or hard liquor. An editor of the New England Journal greeted the report enthusiastically: "It is encouraging to note that not everything one enjoys in life predisposes to disease . . . I am sure that many who read this . . . will be quite willing to drink to that . . ."

A congressional subcommittee spent a July afternoon studying the low rate of hospital use in Hawaii. The hospitalization use rate in Hawaii is apparently one of the lowest in the nation, ie, about 75% of the national average. The living costs here are 20% higher than the U.S. average, but the per capita health expenses are slightly below the U.S. average. One reason cited was that the Japanese in Hawaii are somewhat healthier than the average U.S. resident and are comparatively low utilizers of hospital services . . .

The State Health Department had hoped to immunize 26,000 persons since the epidemic in late May, but thus far, only 12,000 have been shot . . . During the epidemic, there were 363 cases treated, mostly in the 18 to 30 age group . . .

In June, Gov. George Ariyoshi signed into law a bill that repeals the provisions of the 1976 law requiring every physician have \$100,000 worth of medical malpractice coverage. This was thought to be unfair to physicians just starting out and those practicing part time. The amended law also allows the court to award fees on a case-by-case basis taking into account the attorney's experience, the complexity of the case and the time spent and amount awarded, rather than fees up to 40% of the amount awarded. The new law also increases from 25 to 35 the number of attorneys on the list for the medical reconciliation panel; establishes a 6 year statute of limitations on malpractice; allows participants in the State compensation fund to have a liability of \$1 million per claim and a total not to exceed \$5 million for the entire policy.

Another related bill approved establishes a separate

cooperative for physicians who do not belong to the State's medical malpractice fund. The cooperative plan requires a minimum of 250 physicians who will put up a minimum of \$20,000 each for a total fund of \$5 million. All medical malpractice judgments, settlements, and administrative costs will be paid out of the earnings of this trust fund.

Miscellany

Lord Bottomley was having recurrent diarrhea and decided to visit his doctor in London. Enroute in his Rolls Royce, the Lord developed severe tenesmus and told Jeeves to pull over. He rushed into the bushes to relieve himself. After an interminable while, when the Lord had not returned, Jeeves decided to investigate. He heard a faint voice calling for help. Jeeves found the Lord squatting behind a bush with diaphoretic brow . . . "I can't seem to get up. Jeeves, see what the trouble is," he gasped . . . "My God, Lord Bottomley, I think you have closed on a daisy." (From our Medrol man, Richard Bell)

Doctors in Print

The *Lancet*, Jul 16 '77 p 110 "Bowel Transit Time and Stool Weight in Populations with Different Colon-Cancer Risks" **Gary Globber**, **Abraham Nomura**, **Shigetoshi Kamiyama**, **Akio Shimada**, **Boniface Abba**. Investigation of 25 caucasians, 67 Hawaii Japanese, and 28 Japanese in Akita, Japan reveal that bowel transit times are similar in the two Japanese groups, but the Hawaii Japanese and Hawaii caucasians have significantly lighter stools and this factor may be indirectly related to their higher risk of colorectal cancer, polyposis and diverticulosis.

Personalities

Kuakini pathologist, **Grant Stemmerman**, speaking on Schistosomiasis describes the male and female parasites as "being in a state of perpetual copulation lasting 25 to 30 days . . . It simply boggles the mind."

We were discussing the frailties of foreign language grammar and **Mel Kaneshiro** recalled a high school latin teacher who simply abhorred dangling participles. "I still don't know what it is," Mel said ruefully . . .

Ron Pion and **Jerry Hopkins** have authored a book with the intriguing title, "The Last Sex Manual" which is due to become available in November. It deals with behavior modification and promises new, quick, and final ways to overcome the 10 most common sexual complaints . . .

Elected, Appointed, & Honored

The Hawaii Chapter, American Academy of Pediatrics, held their installation dinner in August at the Ft. Shafter Officers Club. Installed for 3 year terms were: Chapter chairman, **Henry Yim**; alternate chairman, **Robert Latta**; secretary, **Roy Niimi**; treasurer, **Amelia Jacang**; member at large, **Fernando Atienza**; and nominating committee chairman, **Mitsuo Tottori**.

Gary Globber has been invited to talk on gastric Ca in Rio de Janeiro for the 15th Pan American Conference on Gastroenterology in October . . . **Mel Kaneshiro** was recently named fellow of the American College of Physicians at its recent meeting of the College's Board of Regents in Dallas . . . **George Mills** became the first Hawaii physician elected to the 12 member Board of Trustees of the AMA at the San Francisco meeting . . . **Albert Chun Hoon** was newly elected to the HMSA board at their 39th annual meeting . . . The Honolulu Unit of the American Cancer Society elected **James Navin** vice president and new board members, **Leonard Howard**, **Kevin Loh**, **Kenneth Minato**, **Francis Oda**, **Lonnie Tiner**, and **Quintin Uy**. Reelected to the board were **Carl Boyer Jr**, **Andre Choan**, **Paul De Mare**, **John Edwards**, **Norman Goldstein**, and **Noboru Oishi** . . . The Maui Unit of the American Cancer Society elected **Donald Dietrich** president, **Russell Todd** vice president and new board members, **Sidney Clark**, and **John Withers**. On Kauai, **Yonemichi Miyashiro** was appointed to the Board of Health, **Thatcher Magoun** and

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Robert Melton to the Kauai County Subarea Health Planning Council, **Peter Kim** to the County Hospital Management Advisory Committee, **Patrick Aiu** to the Board of Medical Examiners and **Ronald Hattis** to the Advisory Council on Pesticides . . .

Bulletins

Jan 23-28 1978, 5th Annual Neurological Update. Miami Beach, Florida. Sponsored by the Dept. of Neurology, U of Miami School of Medicine. AMA Accredited. Adult Neurology 4½ days, 25 hrs; child neurology, 1-1½ days, 8 hours. Combined program 6d, 33 hrs. Director: Peritz Scheinberg, MD Information: Div. of Continued Medical Education, U of Miami, School of Medicine, P.O. Box 520875, Miami, FL 33152 Tel (2305) 547-6716.

The Report of the Joint National Committee on Detection, Evaluation, & Treatment of High Blood Pressure. Available in August. Copies may be ordered from High Blood Pressure Information Center, 12/80 National Institutes of Health, Bethesda, Maryland 20014.

Miscellany

(Paul Condit's repertoire . . .)

A disgruntled tourist was venting his pent up frustrations about everything at a Waikiki bar . . . The bartender listened politely till the tourist remarked, "This damn town is the A--hole of the world . . ." The bartender commented innocently, "I assume you are passing through . . ."

Professional Moves

In our 12 years as Notes & News editor, never have we seen such mass migration of *Homo Sapiens Medicus* in this community . . . For July, we already reported on internist **John Morris** and OB man **Clayton Hombo** moving into the Queen's Physicians' Office Bldg.; pediatrician **Jiro Saegusa** joining the Pediatric Associates Inc.; allergist **Robert Thume** joining the Fronk Clinic; cardiologist **Ernest Lee** relocating to 1441 Ala Moana; eye man **Harvey Minatoya** joining his dad at 1003 Pensacola; ENT man **Roland Tam** joining the Pang Clinic; pediatrician **Carlos Robles** joining the Kauai Medical Group and **Charles Morin** a/c the Kohala Dispensary Ltd. Later in July, pediatricians **Raymond Wong** and **Richard Mitsunaga** relocated to 98-1238 Kaahumanu St., Pearl City; pediatrician **Eric Kawaoka** joined **Calvin Sia** at 1350 So. King St.; infectious disease expert **William Lau** joined **Richard Frankel** at Harkness Pavilion, QMC; OB man **Keijiyo Yazawa** relocated to Suite 940 Kapiolani-Children's Med Center; internist **Fred Tanabe** a/c Pearl City Medical Associates Inc. . . . The OB group of **Philip McNamee** and **Carl Morton** relocated to Suite 980 Kapiolani Hospital; internist **Michael Dimitrion** joined **Ted Tomita** at 94-801 Farrington Highway . . . The Kaiser Permanente Medical Care Program added internist **Richard Lau**, infectious disease expert **Michael Sands**, internist **N. Fred Myers**, and nephrologist **Robert Morrison**. On the Big Island, **Daniel Dreux Sowinski** joined the Hilo Medical Group. On the Health Department front, director George Yuen reassigned deputy director **Audrey Mertz** to Chief of the Medical Health Services Division. **Russel Pierce**, former chief of the division, was reassigned to Chief of the Emergency Medical Branch. **Verne Waite**, chief of Hospital and Medical Facilities, was reassigned as deputy director.

Now, on to August . . . Urologist **Andy Morgan** and OB man **Ed Matsuoka** moved into the Queen's Physicians' Office Bldg. . . . The Honolulu Medical Group acquired ENT man **Kenneal Chun** and the Fronk Clinic (at Pearl Ridge) gained radiologist **Larry Patchell** . . . Infectious disease man **Peter Vei-Way Miao** joined **Steven Berman** at 373 Alexander Young Bldg. . . . Urologist **Thomas Ito** opened at Suite 330 Professional Center Bldg.; **Joseph Tsai** moved to the Honolulu Federal Savings & Loan Bldg. at 45-1144 Kam Hwy., Kaneohe; internist **Jose C. De Leon** opened at Suite 320 Newtown Square Bldg., Aiea; and "plastic surgeon **Bob Flowers** has blossomed out with a new company: Plastic

Surgery Center, Inc." (according to Daacon) . . . On Maui, urologist **Glenn Haines** opened at the Maui Clinic and in Hilo, internist **Ravindra V. Mashruwala** specializing in nephrology and hypertension opened at 670 Ponahawai St.

Then in September, the flood gates were opened and we had a real deluge. Into the Queen's Physicians' Office Bldg. marched **Sylvia Pager** specializing in pediatrics and adolescent medicine; internist-oncologist **Thomas Lau**; the Pediatric Medical Group Inc. of **Fely B. Ylarde**, **Emiko Sakurai** and **Amelia Jacang**; internist **Bernard Fong**; internist **Benjamin Lee Gordon II**; ENT men **Kazuo Teruya** and **Gene Doo**; Surgeon **George Nip**; the Orthopedics Associates of Hawaii including **Stanley Chung**, **Albert Chun Hoon**, **James Doyle**, **Lawrence Gordon**, **Eugene Lance**, **Alan Pavel** and **Thomas Walinski**; the Nephrology Associates Inc. including nephrologists **Arnold Siemsen**, **Eugene Wong**, **Jared Sugihara** and **James Musgrave** (a pediatric nephrologist). Moving into Kapiolani Children's Center were orthopedist **Stanley Chung** (who is also with Orthopedics Associates of Hawaii located at Queen's) and child neurologist **Robert Bart Jr.** Joining the Honolulu Medical Group Inc. were hematologist-oncologist **Niranjan Rajdev**, psychiatrist **John Clarkin**, radiologist **John Cieply** and GP **David McEwan** . . . Joining the Straub Clinic were internist **Vincent Aoki** and gastro-enterologist **William Hartman**.

Meanwhile the Fronk Clinic purchased Leeward Hospital for \$3.19 million from **Howard Liljestrand** and renamed it the Pearl Ridge Hospital. The Leeward Clinic was also renamed the Fronk Clinic-Pearl Ridge, and cardiologist **Danelo Canete** became medical director of the Pearl Ridge Hosp. Allergist **Robert Thune** was also assigned to Fronk Clinic-Pearl Ridge . . . General surgeon and pediatrician **Manuel Ang** joined the Dickson-Bell Medical Center and anesthesiologists **Ralph Suetsugu**, **Than Tun** and **Lloyd Jones** a/c Medical Anesthesia, 1374 Nuuanu Ave. Internist **Kenneth Zienkiewicz** joined the Kaiser-Permanente Group. There are still those fiercely independent souls going solo . . . Internist **Birendra Huja** opened at the Alexander Young Bldg.; thoracic and cardiovascular surgeon **Collin Pang** opened at Rm.133 Harkness Pavilion, QMC; and dermatologist **David Huntley** opened at both Kailua Medical Arts Bldg. and the Kaneohe Business and Professional Center.

Finally, on the neighbor islands, psychiatrist **Marvin Mathews** joined **Alfred Arensdorf** at the Maui Professional Center and internist **Michael Famularo** joined the Maui Clinic at Kahului . . . On Kauai, **John Newman** joined the Kauai Medical Group . . .

Porogee Jokes . . .

(by Al Lunning, our golfing partner)

"Do you know why the Porogee's seldom have hemorrhoids?" We admitted we hadn't known of this medical fact . . . "Because God made them perfect asses . . ."

A Review of The Malpractice Situation

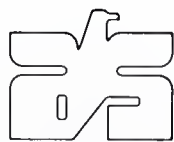
(Information gleaned from the Pacific Business News article by Debra Whitefield)

The consensus is that the local malpractice crisis is over, viz the number of lawsuits has dropped sharply, but the awards to patients are climbing and the insurance premiums continue to rise, though at a slower rate than a year or two ago. Argonaut last raised its premiums on July 1st and Hawaii doctors will pay \$1,390 to \$12,838 for \$100,000 per claim and another 30% of the annual premium into the State compensation fund, thus bringing the figures to \$1,807 to \$16,680 for the 1,400 practicing physicians in Hawaii. The HMA cites \$3,432 as the average premium plus 30% so that the typical doctor pays \$4,461 this year. In contrast, from 1971 to 1974, the insurance rates ranged from a low of \$431 to a high of \$2,722 for \$100,000 per claim.

With the establishment of the Medical Claims Conciliation

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Panel by the 1976 law, there has been a 50% reduction in the number of suits filed, ie of the 77 complaints reviewed, only 20 were taken to court after panel review . . .

Visiting Professors

David Sabiston Jr., professor of surgery from Duke University, lectured on coronary circulation and quoted Sir Isaac Newton: "We see so far because we stand on the shoulders of giants."

re Unique features of coronary circulation: maximum blood flow in diastole; high oxygen utilization; capacity for massive vasodilation; and minimal of natural collateral vessels . . .

re Hypoxemia on coronary blood flow: 500% increase in CBF within 60 seconds with 6% O₂ . . .

re Deaths from MI: 600,000 per year in the US . . .

re Coronary by-pass surgery: 2/3 of the patients have complete relief of pain . . . Whether it prolongs life?

Still while the consensus is that the crisis is over, at least 500 doctors feel that the answer is an end to traditional malpractice insurance. Between 200 to 300 physicians have opted for self insurance, another 240 have joined HAPI (Hawaii Association of Physicians for Indemnification) and still others are seriously considering forming their own insurance companies . . . 10% of Hawaii physicians have paid the \$200 initiation fee to join HAPI. The \$200 covers application and screening expenses and once accepted, there are annual membership dues of \$500 and a refundable trust deposit ranging from \$10,000 to \$35,000 depending on the specialty. Malpractice settlements are to be paid from the trust earnings which by law must total \$5 million. HAPI needs a minimum of 250 members and the Department of Regulatory Agencies has given HAPI until August 1979 to accumulate the \$5 million trust fund. The trust fund deposits are refundable when the member withdraws from practice. HAPI expects to save as much as 75% of the yearly premium based on the experience of a Los Angeles-based non-profit group. At \$500 a year for dues, the members will be guaranteed a \$1 million coverage per claim, but should the trust be depleted, members would be assessed further . . .

The Physicians' Protection Association of Hawaii on the other hand is organized around the concept that the physicians should go bare and fight every malpractice suit . . .

Emergency physicians have joined their counterparts on the mainland for insurance, and other specialty groups are planning similar moves.

Porogee Jokes . . .

(Courtesy of Louise Tokumaru)

The Porogee refuse to kill flies because its against the law to kill the national bird . . .

You know why Porogee children never play in sand boxes? Because the cats will cover them up . . .

A Haole, a Buddhahead and a Porogee broke out of Halawa Jail one midnight . . . Soon the guards with bloodhounds were sniffing down their tracks . . . The Haole climbed a kiawe tree. When the bloodhounds surrounded the tree and the guards started to shine their flashlights into the branches, the Haole prisoner cried, "Meow! Meow!" The guards yelled at their dogs, "You stupid dogs, you treed a cat!" and went on their way. The Buddha head saw what happened so he climbed a coconut tree. When the bloodhounds came around, he hooted, "Hoo! Hoo!" The guards were satisfied and continued their search. The Porogee prisoner climbed a banyan tree and when the dogs converged on the tree, he gave out with: "Moo! Moo!" (A similar version also told by Henry Yim)

Two Porogee workers drove their truck to Kaneohe to fix a roof. When they got there, Manuel ordered, "Get the ladder from the truck." Alfred replied, "You never told me to bring the ladder." Manuel slapped Alfred's face, "You stupid bug-gah! How you think we gonna fix the roof." Manuel thought and thought, then came up with a great idea. He took the flashlight from the glove compartment and told Alfred,

"Here, I'll shine the beam on the roof so you can climb up the beam." Alfred knew better. "You think me dumb or what? When I get up half way, you gonna shut off the light and let me fall . . ."

How To Deal with the Terminally Ill . . .

(Notes from an excellent lecture by psychiatry professor Yano at Kuakini Hospital . . .)

Most of us have had training geared towards curing others . . . Nothing in our curriculum on dealing with the terminal patient . . . Our training is meager so we feel frustrated and then we avoid . . . We must think of *caring* rather than *curing* . . . This may help us in our attitude towards the terminal patient . . . Our society is too technical and impersonal—ie very efficient and very inhuman . . . But machines cannot replace human contact . . . For the dying patient, the doctor-patient relationship is most important . . . It is not a pleasant or exciting kind of treatment . . . The first question is, should the patient be told his condition? Dr. Cooper Ross interviewed hundreds of such patients . . . Over half had not been told, but they knew . . . Thus "The conspiracy of silence." Patients have told Dr. Ross, "They know I have cancer, but they don't want to talk about it." The patient is concerned about his condition and therefore anxious . . . He has fantasies about his condition . . . The patients say, "We want *honesty, compassion and company.*"

re Honesty: How to tell the patient . . . Set aside 30 minutes at the bedside . . . Explain the seriousness of the illness.

Allow for patient questions . . . Explain the tests and procedures . . . The patient may use *denial* . . .

re Compassion: Give verbal as well as non-verbal support . . . Let the patient ventilate . . .

re Company: They want company instead of abandonment . . .

re Your Own Feelings: It's OK to have sad feelings or bad feelings . . . You have to recognize your own feelings about the patient . . . Then you can accept their outbursts and actions . . .

re Communication pathway between physician and dying patient: Both verbal and non-verbal pathways . . . Be active listener . . . Non-verbal communication includes eye contact, posture, touching, holding, etc.

re Stages of Dying patient: First denial (both adaptive and maladaptive); then anger; third, bargaining, fourth, depression and preparatory grief; finally acceptance . . . "I avoid using antidepressants and use supportive psychotherapy . . ."

Our "Angels"

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Valium (diazepam) is a benzodiazepine with a character all its own.

Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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**a prudent choice in psychic
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



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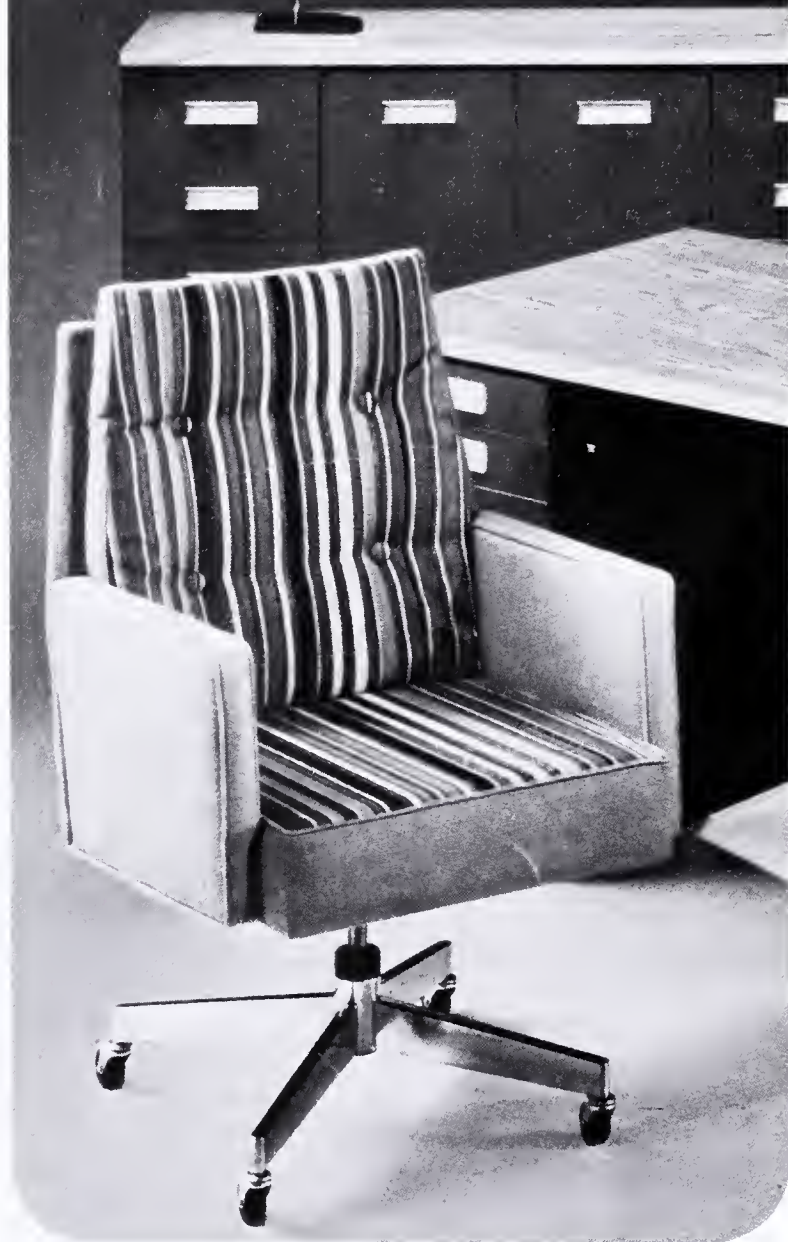
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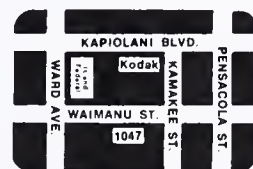
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A close-up photograph of a woman's upper back and shoulder. She has dark hair and is looking down. Her right hand, with red nail polish, is touching a patch of skin on her left shoulder that is covered in small, red, inflamed lesions characteristic of allergic dermatitis. The background is dark and out of focus.

Allergic Dermatoses...

Contraindications: Hypersensitivity to hydroxyzine. Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit, induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate to establish safety in early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as meperidine and barbiturates. In conjunctive use, dosage for these drugs should be reduced. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

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with strong emotional overlay

the cause can be obscure

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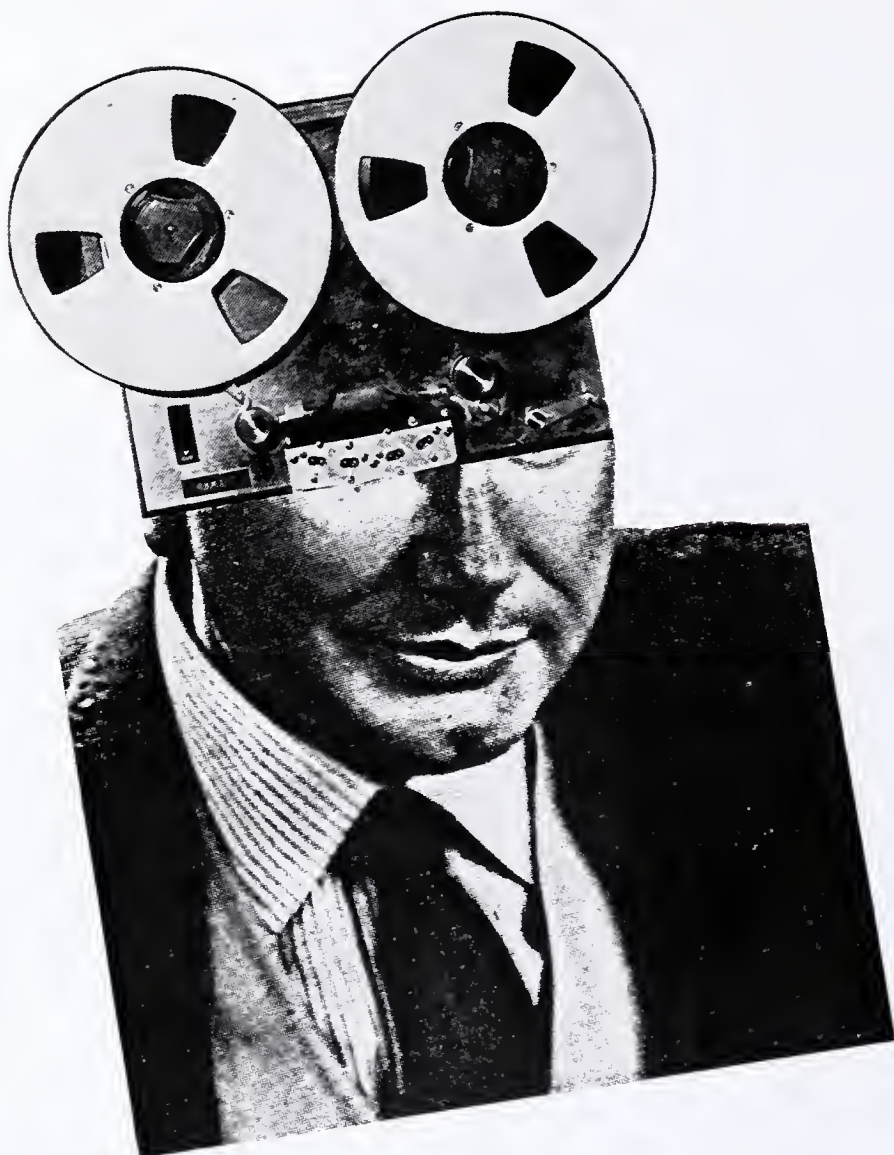
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Warnings: Drug dependence. Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to other oral narcotics. Subject to the Federal Controlled Substances Act. Usage in ambulatory patients: Caution patients that codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery. Interaction with other CNS depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) with this drug may exhibit additive CNS depression. When such a combination is contemplated, reduce the dose of one or both agents.

Usage in pregnancy: Safe use not established. Should not be used in pregnant women unless potential benefits outweigh possible hazards.

Precautions: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce

adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions. Codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to certain patients such as the elderly or debilitated and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequent: lightheadedness, dizziness, sedation, nausea and vomiting, more prominent in ambulatory than nonambulatory patients, some of these reactions may be alleviated if the patient lies down. Others: euphoria, dysphoria, constipation and pruritus.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For information on symptoms and treatment of overdosage, see full prescribing information.

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WASHINGTON, Aug. 26, 1920—
struggle for Women's



Social Security Bill Is Signed; Gives Pensions to Aged, Jobless

Roosevelt Approves Message Intended to Benefit 30,000,000
Persons When States Adopt Cooperating Laws—He Calls
the Measure 'Cornerstone' of His Economic Program

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10,
1971—The Senate approved
today, 94 to 0, and sent to the

WASHINGTON, Aug. 14
The Social Security Bill, providing
a broad program of unemployment
insurance and old age pensions,
and counted upon to benefit
20,000,000 persons, became law
today when it was signed by
President Roosevelt in the presence
of those chiefly responsible for
bringing it through Congress.

Mr. Roosevelt called the bill
"the cornerstone in a structure
which is being built but is
nearly complete."

TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

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"If we fail to use it," he declared
to the solemn final meeting of the
delegates, 'we shall betray all of
those who have died in order that
we might meet here in freedom and
safety to create it.'

"If we seek to use it selfishly—for
the advantage of any one nation or
any small group of nations—we
shall be equally guilty of that be-
trayal."

Fervent Interpolation

The President, speaking in the
auditorium of the War Memorial
Opera House, built in memory of
sons of the Golden Gate city who
gave their lives in the first World
War, in which he himself served,
seemed to give unconscious expres-
sion to the solemn feeling of the
occasion when, at the outset of his
speech, he interpolated the words,
half a hope, half a prayer:

"Oh, what a great day this can
be in history!"

the Draft Ends No

WASHINGTON, Jan. 27,
1973—"With the signing of
the peace agreement in
Paris today, and after re-
ceiving a report from the

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

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The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.



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Survival Patterns From Large Bowel Cancer in Hawaii

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• From 1960 through 1973, the Hawaii Tumor Registry identified 1485 cases of colon cancer and 887 of rectal cancer among the 5 larger racial groups in Hawaii: European (a.k.a. "white" or "Caucasian"), Chinese, Filipino, Hawaiian and Japanese. Subsequent analysis of survivorship from large bowel cancer revealed that colon cases had a 42% higher 5-year relative survival rate than rectal cancer cases. Men and women were comparable in their survival from large bowel cancer. As expected, patients with localized disease did much better than those who had more advanced spread of disease. With respect to race, Japanese and Europeans had higher rates of survival than Filipinos and Hawaiians. However, other factors which may affect survivorship, such as histologic grade of the lesion and socioeconomic variables could not be incorporated into this study. Until such factors are also considered in the analysis, the observed results are only suggestive of racial differences with regard to survivorship.

The Hawaii Tumor Registry began in 1960. Since that time, it has served as a data bank from which information has been derived in many ways. Through cooperative efforts of the Hawaii Tumor Registry and the Epidemiology Unit of the Cancer Center of Hawaii, a study has been conducted to identify survival patterns from large bowel cancer in Hawaii.

Studies of survivorship from large bowel cancer are particularly important; this malignancy has the highest incidence of any type of

cancer, except skin cancer, in the United States.¹ Past investigations have shown colorectal cancer patients do differ in survival according to the site of origin of the tumor (colon or rectum),^{2,3} histologic grade,⁴ extent of disease,⁵ and patient characteristics such as age⁴ and sex.^{6,7}

Whether race is a determinant of survival in colon or rectal cancer is unclear. Studies involving whites and blacks in the U.S. have suggested no racial differences, after allowance was made for other prognostic variables.^{4,8} Internationally, comparisons of survivorship among racial groups would be difficult to analyse because of inter-country differences in diagnostic practices, criteria for determining malignancy, facilities for diagnosis and follow-up, and other practices.

In Hawaii, such problems are minimized: health practices are reasonably standardized within the State; diagnostic methods and criteria for determining malignancy are fairly uniform. These factors, along with Hawaii's multi-ethnic population and geographically isolated setting, make it a suitable place to conduct survivorship studies of large bowel cancer, with respect to race and other prognostic factors.

Methods

Since 1960, the Hawaii Tumor Registry (HTR) has compiled information on Hawaii residents who have been hospitalized with different types of cancer, and their subsequent follow-up status. From 1960 through 1973, 1,611 cases of colon cancer and 993 of rectal cancer were identified. Among the cases, there were 1,081 (42%) Japanese, 791 (30%) European, 271 (10%) Filipinos, 227 (9%) Chinese, 177 (7%) Hawaiians and 57 (2%) in the "Other" category. Because of the small number in the "Other" category, it was excluded from this investigation. Of the 2,547 remaining cases, there were 80 (3%) with *in situ* cancer; and information was not available on an

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additional 95 (4%) cases to determine the extent of disease. Consequently these 175 cases were eliminated from subsequent analysis. In all, there were 1,485 colon and 887 rectal cancer patients who had either localized, regional or distant spread of their tumor; they are included in this study.

For purposes of this investigation, the racial classification was primarily based on self-classification. For those who stated they were of mixed parentage, any person with Hawaiian extraction was classified as Hawaiian. As a result, the Hawaiian category included 34.5% of Hawaiian-European mixture, 23.0% of Hawaiian-Chinese, 22.4% of pure Hawaiian and the remainder of other races in addition to Hawaiian. The following per cent of the Japanese, European, Filipinos and Chinese were categorized as being of one race: 100%, 100%, 100% and 98.5%, respectively.

Cases were reported to the HTR by hospital personnel. Annual follow-up was conducted by hospital personnel, with the assistance of personnel from the HTR whenever necessary. Most of the follow-up information was provided by the patient's personal physician.

Because the whereabouts of 23.1% of the colorectal cancer patients as of January 1, 1974 was unknown, a special effort was made during the summer of 1975 to determine the status of these persons. As a consequence, the per cent lost-to-follow-up was reduced to 5.6% (134 of 2372 cases).

The persons lost-to-follow-up are listed in Table 1 by race and site of tumor origin. Whites with colon cancer and Filipinos with rectal cancer had proportionally more persons lost-to-follow-up. In the analyses, the persons lost-to-follow-up were included until the time their whereabouts were last known. From that point on, they were

TABLE 1.—Persons lost-to-follow-up by race and site of origin of large bowel cancer

RACE	COLON		RECTUM	
	TOTAL	NUMBER LOST-TO-FOLLOW-UP (%)	TOTAL	NUMBER LOST-TO-FOLLOW-UP (%)
European ("Caucasian")	455	40 (8.8)	263	14 (5.3)
Japanese	642	29 (4.5)	378	17 (4.5)
Chinese	130	2 (1.5)	78	2 (2.6)
Filipino	139	10 (7.2)	119	11 (9.2)
Hawaiian	119	7 (5.9)	49	2 (4.1)
Total	1485	88 (5.9)	887	46 (5.2)

TABLE 2.—Distribution of colon and rectal cancer cases by sex, race and extent of disease

RACE	MALE				FEMALE			
	LOCAL	REGIONAL	DISTANT	TOTAL	LOCAL	REGIONAL	DISTANT	TOTAL
<i>Colon</i>								
European ("Caucasian")	88 (42)	73 (35)	49 (23)	210 (100%)	89 (36)	94 (38)	62 (25)	245 (99%)
Japanese	148 (43)	132 (38)	64 (19)	344 (100%)	123 (41)	125 (42)	50 (17)	298 (100%)
Chinese	27 (36)	33 (45)	14 (19)	74 (100%)	24 (43)	19 (34)	13 (23)	56 (100%)
Filipino	42 (37)	48 (43)	22 (20)	112 (100%)	5 (18)	11 (41)	11 (41)	27 (100%)
Hawaiian	23 (37)	16 (25)	24 (38)	63 (100%)	23 (41)	17 (30)	16 (29)	56 (100%)
Total	328 (41)	302 (38)	173 (22)	803 (101%)	264 (39)	266 (39)	152 (22)	682 (100%)
<i>Rectum</i>								
European ("Caucasian")	47 (32)	69 (48)	29 (20)	145 (100%)	51 (43)	41 (35)	26 (22)	118 (100%)
Japanese	117 (49)	93 (39)	28 (12)	238 (99%)	75 (53)	47 (33)	18 (13)	140 (99%)
Chinese	20 (36)	21 (38)	14 (25)	55 (99%)	12 (52)	6 (26)	5 (22)	23 (100%)
Filipino	30 (29)	43 (41)	31 (30)	104 (100%)	8 (53)	6 (40)	1 (7)	15 (100%)
Hawaiian	13 (42)	13 (42)	5 (16)	31 (100%)	9 (50)	6 (33)	3 (17)	18 (100%)
Total	227 (40)	239 (42)	107 (19)	573 (100%)	155 (49)	106 (34)	53 (17)	314 (100%)

considered as “withdrawn alive,” which is the standard approach based on the assumption that the subsequent experience of such persons is similar to those who were not lost-to-follow-up. This assumption is more acceptable with a low percentage of lost-to-follow-up, which is the case in this study.

For analyses, the *relative* survival rate, developed by Ederer and associates,⁹ was utilized. This rate is defined as the ratio of the observed survival rate to the expected rate for a group of people in the general population similar to the patient group with respect to sex, age, race and calendar period of observation, but free of the specific disease under study. The relative survival rate, therefore, is the rate that would have occurred if the group had died only from large bowel cancer. For example, if Europeans as a group live longer than Hawaiians, then Europeans with colon cancer may live longer than Hawaiian colon cancer patients, even if mortality from colon cancer is the same between the two groups, because fewer Europeans with colon cancer would die from other causes. The relative survival rate adjusts for the difference between Europeans and Hawaiians due to other causes of death and thus makes possible meaningful comparisons of the survival experience of both racial groups from colon cancer alone.

Results

The distribution of cases by site, sex, race and extent of disease is given in Table 2. Proportion-

ally more of the Japanese men with rectal cancer were diagnosed with local involvement, while more of the Filipino men with rectal cancer and Filipino women and Hawaiian men with colon cancer were seen with distant spread of the disease. With respect to the findings by sex and site, more women with rectal cancer were diagnosed with localized disease than any of the other groups.

Table 3 shows the comparison between the cumulative survival rate and the cumulative *relative* survival rate among men with localized colon cancer. The cumulative survival rate is the actual rate of survival, ie, 80% of European men with localized colon cancer survived 3 years after their diagnosis. If other causes of death besides colon cancer could be eliminated, 88% of European men with localized disease would survive 3 years (cumulative relative survival rate), while 12% would succumb to cancer of the colon.

The 3-year and 5-year relative survival rates for each specific group by site, sex, race and extent of disease are shown in Tables 4 and 5. In most comparisons, those with localized disease had better relative survival rates than patients with regional spread. There were a few exceptions to this observation among the Filipinos and Hawaiians. However, this may be attributed to the instability of the rates due to the small number of cases in the respective categories. As expected, patients with distant spread did much worse than those with more limited disease at time of diagnosis.

TABLE 3.—The cumulative survival rate and cumulative relative survival rate of men with localized colon cancer by race

SURVIVAL RATE	EUROPEAN ("CAUCASIAN")		JAPANESE		CHINESE		FILIPINO		HAWAIIAN	
	CSR*	CRSR**	CSR	CRSR	CSR	CRSR	CSR	CRSR	CSR	CRSR
3 year	.80	.88	.77	.85	.70	.76	.63	.70	.67	.75
5 year	.71	.81	.67	.80	.47	.55	.57	.68	.62	.74
10 year	.54	.70	.49	.67	.47	.68	.27	.39	.43	.61

*cumulative survival rate
**cumulative relative survival rate

TABLE 4.—Cumulative 3-year and 5-year relative survival rates for colon cancer by sex, race and extent of disease

RACE	MALE			FEMALE		
	LOCAL	REGIONAL	DISTANT	LOCAL	REGIONAL	DISTANT
3-year rates						
European ("Caucasian")	.88	.82	.13	.89	.65	.12
Japanese	.85	.67	.13	.90	.69	.10
Chinese	.76	.63	.15	.90	.65	.08
Filipino	.70	.76	.20	.62	.67	0
Hawaiian	.75	.42	.17	.70	.56	.08
5-year rates						
European ("Caucasian")	.81	.66	.13	.77	.59	.12
Japanese	.80	.57	.12	.85	.64	.03
Chinese	.55	.57	0	.79	.55	0
Filipino	.68	.58	.07	.63	.39	0
Hawaiian	.74	.34	.10	.58	.62	0

TABLE 5.—Cumulative 3-year and 5-year relative survival rates for rectal cancer by sex, race and extent of disease

RACE	MALE			FEMALE		
	LOCAL	REGIONAL	DISTANT	LOCAL	REGIONAL	DISTANT
<i>3-year rates</i>						
European ("Caucasian")	.86	.69	.05	.74	.62	.23
Japanese	.85	.64	.13	.85	.59	.09
Chinese	.71	.65	.43	.69	.88	0
Filipino	.72	.66	.03	.88	.65	0
Hawaiian	.52	.43	.21	.46	.56	.36
<i>5-year rates</i>						
European ("Caucasian")	.67	.52	0	.71	.45	.05
Japanese	.79	.57	.08	.83	.57	0
Chinese	.66	.55	.09	.71	.54	0
Filipino	.39	.48	.04	.89	.33	0
Hawaiian	.56	.29	.21	.47	.40	0

TABLE 6.—Comparisons of cumulative 5-year relative survival rates between paired groups after adjustment for other variables in the table

HIGHER RATE VS. LOWER RATE	% HIGHER SURVIVAL RATE	CHI-SQUARE VALUE
<i>Race</i>		
Japanese vs. European	19%	1.97
Japanese vs. Chinese	58%	6.18*
Japanese vs. Filipino	81%	12.31**
Japanese vs. Hawaiian	129%	17.84**
European vs. Chinese	34%	2.24
European vs. Filipinos	62%	6.70*
European vs. Hawaiian	93%	10.31**
Chinese vs. Filipinos	17%	0.36
Chinese vs. Hawaiian	41%	1.72
Filipino vs. Hawaiian	15%	0.21
<i>Sex</i>		
Female vs. Male	3%	0.07
<i>Site</i>		
Colon vs. Rectum	42%	11.54**
<i>Extent of Disease</i>		
Local vs. Regional	130%	69.58**
Local vs. Distant	4140%	578.12**
Regional vs. Distant	1686%	311.08**

*P<.05

**P<.005

In general, the Europeans and Japanese appeared to have better relative survival rates than the Filipinos and Hawaiians in Tables 4 and 5, but this pattern was not uniformly observed in every instance.

Table 6 compares the 5-year cumulative relative rates by site, sex, extent of disease and racial groups after adjustment was made for the other variables in the table by utilizing the Mantel-Haenszel test.¹⁰ In this manner, 5-year survivorship differences between Japanese and Europeans can be determined after controlling for sex, cancer site and extent of disease. When this was done, there were no significant differences (at p<.05) between the two racial groups, although Japanese had a 19% higher survival rate than Europeans. When comparisons were made with other racial groups, Japanese did have a significantly better survival rate than Chinese, Filipinos and Hawaiians, while Europeans fared

better than Filipinos and Hawaiians.

As expected, the colon cancer cases had a significantly better survival rate than rectal cancer cases and those with localized lesions did much better than those with regional or distant spread of their tumors. The women and men were similar in their survival from large bowel cancer.

Discussion

There are inherent advantages in conducting survivorship studies in different patient groups that receive their medical care in the same geographic region. Differences between the groups in factors related to survival, such as diagnostic practices, criteria for determining malignancy and treatment regimens are greatly minimized. Moreover, the quality of medical care is better standardized for patients from one region than among those from many regions or countries.

For this reason, survivorship studies among the several groups in Hawaii as determined by cancer site, sex, ethnicity and extent of disease are particularly informative.

Another distinct advantage of survivorship analysis in Hawaii was the availability of the data base from which relative survival rate can be determined. This rate corrected for the expected mortality that would be observed in the general population. The correction adjusted for differences between groups by appropriate factors. It is an effective tool which makes the interpretation of survival data more meaningful.

Possible shortcomings in the present study exist. It is unknown how many cases of large bowel cancer among Hawaii residents were not identified by the HTR. If the numbers were high and if such unidentified cases differed in some significant way from the registered cases, then the findings of this study would be biased. Because of the extensive hospital surveillance system in Hawaii, it is likely that no more than a small percentage of cases was missed by the HTR.

Another point to consider is that the presence of unstaged cases (95) and lost-to-follow-up cases (134) detracted from the completeness and follow-up of this study. However, because of their relatively small numbers, it is unlikely that this limitation has biased the data to any significant degree.

As expected, the findings indicate that extent of disease is the major prognostic factor of large bowel cancer. Patients with localized or regional disease fared much better than those with distant spread of their disease process. Eker's series⁵ of surgically-treated colorectal cancer cases also noted important variation in survival by stage, as

did studies by groups headed by MacLeod³ and Berge.²

Cancer site was also a noteworthy factor in survival, as colon cancer cases experienced better prognosis than rectal cancer cases. Similar observations have been made by Berge et al² and by Godwin and Brown,⁴ but not in Hultborn's series.¹¹

Past studies⁶⁻⁸ suggested that women with large bowel cancer had a survival advantage over men, but the present study found no difference between the sexes in survival patterns. A similar lack of differences was noted by MacLeod et al.³

When survivorship comparisons were made by racial groups, Japanese and Europeans had significantly better relative survival rates than Filipinos and Hawaiians; Japanese also had better rates than Chinese. Unfortunately, data are not available with respect to other variables which may affect survivorship and should be adjusted for in the analyses. Such variables include histologic grade of the lesion and socio-economic factors, among others. Until such factors are also considered in the analyses, the observed results are only suggestive of racial differences with respect to survivorship from large bowel cancer.

With continual monitoring of the Hawaii population for the occurrence and survivorship of cancer, it is expected that further informative data will be collected about the patterns of cancer in this population.

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Survivorship Among Patients with Nasopharyngeal Carcinoma in Hawaii

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• *Since 1965 in Hawaii, the mean 5-year survival rate for patients with nasopharyngeal carcinoma has been 30.4 percent. During October-November, 1976 on Oahu, a survey was made of living patients which revealed that among 30 patients diagnosed before 1974, 80 percent had survived 5 or more years.*

Nasopharyngeal carcinoma (NPC) has its highest recorded incidence rates in Chinese populations and especially among those who originate from Kwangtung Province in south-eastern China.¹ The Chinese of Hawaii are no exception; the age standardized incidence rates for NPC for other ethnic populations in the state are less than those for the Chinese (Table 1). The low incidence rates for Caucasians and Japanese conform to rates reported in other countries for these ethnic groups,¹ but the rates for Hawaiians, Filipinos, and "others," are uncertain because case numbers and populations are small and reliable comparative incidence data are lacking. The "other" ethnic group category has rates for both sexes that are almost the same as the Chinese. This group is comprised of persons of minority ethnic groups as well as mixed ethnic stock, and may include some part-Chinese.

Cancer survival rates generally depend on two factors: early detection and effective treatment. In the case of NPC, neither of these factors is easy to achieve, and the 5-year survival rate following a radical course of radiotherapy is generally about 20 percent.² In the United States, for the period 1955-64, a 5-year survival rate of 25 percent for cancers of the nasopharynx (which includes NPC), has been reported.³

Five-year survival rates can be calculated for NPC in Hawaii since 1965. Between 1965 and 1971, the Hawaii Tumor Registry recorded 79 persons with NPC, 24 of whom have survived 5 or more years. This represents a mean 5-year survival rate of 30.4 percent (Table 2). Although based on a comparatively small number of cases the rate indicates a more favorable prognosis in Hawaii than has been reported elsewhere.

During October and November, 1976, a survey was made of NPC patients believed to be living on Oahu. A list of 60 NPC patients who were diagnosed before 1974 and who are now recorded as alive, together with the names of the attending physicians, was supplied by the Hawaii Tumor Registry. The consent of each physician was obtained before any of their patients were approached, and appropriate consent forms were signed both by physicians and patients. The cooperation was excellent.

Of the 60 patients, 30 were established by survey to be alive, and 23 of these were interviewed (Table 3). An additional 6 patients were seen personally but they refused to be interviewed. One could not be interviewed because he was away from Oahu during the survey period. Of these patients, 80% had already survived 5 or more years (Table 4). One had lived almost 25 years since diagnosis.

The sex ratio of these 60 patients was 2.16 to 1 (41 males, 19 females). This sex ratio follows that reported elsewhere, that is, a ratio of 2-3 to 1.²

Of the 23 patients interviewed, 17 were Chinese or part-Chinese. Of the remaining 6, 1 was Caucasian, 2 Filipino, 2 Japanese, and 1 Hawaiian. Among the Chinese, 11 belonged to the subethnic group of Cantonese, 2 were Hakka, and the rest were either part-Chinese or were uncertain as to which subethnic group they belonged (Table 5). The numbers are too small to allow any conclusions, but the pattern of ethnic-

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TABLE 1.—*Incidence Rates per 100,000 per annum, for Nasopharyngeal Carcinoma in Hawaii, 1968-1972, by Ethnicity and Sex*

ETHNICITY	NUMBERS OF CASES		INCIDENCE RATES ¹		1970 HAWAII POPULATION	
	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES
Caucasian	5	5	0.8	0.9	138,018	116,397
Chinese	15	8	11.4	5.5	19,355	18,396
Filipino	1	0	0.3	—	40,309	33,382
Hawaiian	8	3	3.7	1.3	67,691	68,228
Japanese	7	1	1.0	0.1	101,864	106,614
Others	7	4	11.0	5.9	29,138	28,402
Total	43	21	2.2	1.1	396,375	371,419

¹Age standardized to the 1970 Hawaii Population.

Data source: Hawaii Tumor Registry, and Hawaii State Department of Health, "Population Report, No. 3," Research and Statistics Office, Honolulu, June 1975.

TABLE 2.—*Five-Year Survival Rates in 1976 for Hawaii NPC Patients.*

YEAR OF DIAGNOSIS	NO. DIAGNOSED IN EACH YEAR	NO. SURVIVING 5 OR MORE YEARS	5-YEAR SURVIVAL RATE (PERCENT)
1965	7	2	28.6
1966	13	3	23.1
1967	8	0	—
1968	12	3	25.0
1969	11	7	63.6
1970	12	5	41.7
1971	16	4	25.0
Total	79	24	—
Mean	11.3	3.4	30.4

TABLE 3.—*Status of Hawaii NPC Patients Diagnosed before 1974 and Recorded as Living in 1976 by the Hawaii Tumor Registry.*

STATUS	NO. OF PATIENTS	PERCENT
Interviewed on Oahu	23	38.3
Deceased	4	6.7
On other Hawaiian Islands	5	8.3
Out-of-state	6	10.0
Moved, current address unknown	12	20.0
Patient refused to be interviewed	7	11.7
Physician consent not obtained	2	3.3
Physician unknown	1	1.7
Total	60	100.0

TABLE 4.—*Years Survived by Hawaii NPC Patients Who Were Diagnosed Before 1974 and Who Now Live on Oahu.*

NO. OF YEARS SURVIVED	NO. OF PATIENTS	PERCENT
Over 15 years	4	13.3
10 to 14 years	7	23.4
6 to 9 years	10	33.3
5 to 6 years	3	10.0
4 to 5 years	4	13.3
3 to 4 years	2	6.7
Total	30	100.0

TABLE 5.—NPC Patients Interviewed on Oahu, by Ethnicity.

ETHNICITY	PATIENTS		1970 HAWAII POPULATION ¹	
	NUMBER	PERCENT	NUMBER	PERCENT
Caucasian	1	4.3	254,415	33.1
Chinese	17	74.0	37,751	5.0
Cantonese	(11)	(47.8)	—	—
Hakka	(2)	(8.7)	—	—
Other Chinese	(4)	(17.5)	—	—
Filipino	2	8.7	73,691	9.6
Hawaiian	1	4.3	135,919	17.7
Japanese	2	8.7	208,478	27.1
Other	0	0.0	57,540	7.5
Total	23	100.0	767,794	100.0

¹Hawaii State Department of Health, "Population Report, No. 3," Research and Statistics Office, Honolulu, June 1975.

ity follows that reported elsewhere, that is, the highest proportion of cases is found among Chinese, especially those of Cantonese origin.

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J. JUDSON McNAMARA, M.D., VICKY GRANT, R.N.,
and STELLA MATSUDA, Honolulu

● *A review of 242 patients who underwent transvenous endocardial pacemaker from 1966 to 1975 was conducted, indicating a high incidence of electrode withdrawal (15%) and an unusually high incidence of skin erosion over electrode or pacemaker sites. The latter appears to be due to a preponderance in the present series of small statured, thin Oriental patients with minimal subcutaneous fat and little consequent protection against pressure necrosis. Followup was very poor during the first 2 years of placement with only 28% documented patient contact between one and 24 months post-implantation. In the overall results, however, the pacemakers were placed with 0.4% mortality and 57% and 35% 5-year and 10-year survival, respectively. These excellent long-term results, in spite of several areas of deficiency in the present series, confirm the unequaled superiority of the transvenous endocardial route for cardiac pacing.*

Recent development of easily applied myocardial electrodes has renewed interest in limited thoracotomy for placement of permanently implanted cardiac pacemakers. The advantages of the myocardial electrode include superior electrical and physiological pacing characteristics as well as avoidance of a variety of complications of the transvenous route. The trade-off is an increased morbidity and mortality from the extra-pleural pericardiotomy and general anesthesia.¹

A wide variation is reported in the frequency of various complications of the transvenous unit. We reviewed the series at Queen's Medical Center over a 10-year period to discover what specific

complications we had encountered with any significant frequency, in an effort to see what impact a shift to the more frequent use of direct myocardial electrodes might have on our results. The data indicate an incidence of most complications consistent with that in most reported series. Two important characteristics of the series, however, include a 28% lack of followup between one month and 24 months after implantation and exceptionally high incidence of pacemaker erosion.

Methods

In general, the technique for pacemaker placement has been consistent with that previously reported.²⁻⁶ Wide variations have occurred over the years, however, in the use of 1) a specific venous route (external jugular versus internal jugular versus cephalic), 2) prophylactic antibiotics, 3) drainage of the pacemaker pocket, and 4) unipolar versus bipolar pacing modes. All patients had pacemakers placed under fluoroscopy in x-ray with meticulous skin cleansing and aseptic technique.

Patient Material

Placement of a permanent transvenous endocardial pacemaker was performed on 242 patients—from 1966 to 1975, including 160 men and 82 women. Mean age for the entire group was 66.6 years.

Indications for pacemaker placement generally fell into two broad categories: any patient with a documented episode of complete heart block regardless of clinical status and patients with significant atrial arrhythmias and unexplained vertigo or syncope. A more detailed breakdown of the reasons for pacemaker placement is seen in Table 1.

From the Cardiovascular Research Laboratory, Department of Surgery, Queen's Medical Center, Honolulu, Hawaii 96813.

Accepted for publication May, 1977.

TABLE 1.—Reason for Replacement

Heart Block—3°	136
Sick Sinus	69
Tachyarrhythmias	20
Postop	5
Congenital	3
Other	9

TABLE 2.—Unit Information

PACING MODE	
Synchronous (demand)	77%
Asynchronous	23%
ELECTRODE CONFIGURATION	
Unipolar	24%
Bipolar	76%

The pacing mode and types of electrodes are shown in Table 2. Demand units are used almost exclusively at the present time. Medtronic made 71% of all units implanted. The remainder were made by CPI, General Electric, Cordis and Vitatron.

Results

Electrode malfunction was encountered in 36 instances (15%) with the initial implantation, including electrode fracture (11), electrode withdrawal (19), ventricular perforation (5) or exit block (6). Electrode withdrawal was encountered 4 other times during battery replacement.

TABLE 3.—Complications

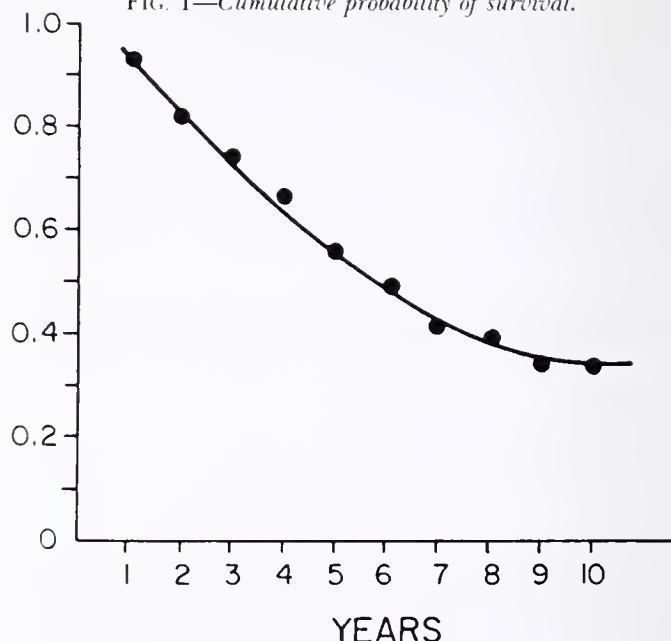
Electrode failure (36 primary)	40
Skin erosion	49
Electrode 11	
Battery 38	
Infection (3 early, 3 late)	6
Cardiac arrest	8
Battery change	215

Skin erosion occurred in 49 patients, 11 in the electrode site and 38 over the pulse generator. Infection in the pulse generator pocket in 6 cases included 3 later episodes (>2 months) that may have been associated with incipient erosion, as it is occasionally difficult to tell which came first.

Cardiac arrest occurred 8 times as a consequence of electrode failure or battery malfunction, the latter usually occurring in patients with inadequate followup. No documented evidence of a pacemaker check between one and 24 months following implantation was recorded in 28% of patients. Followup, however, improved dramatically beyond 24 months.

Observed survival rates for all patients shows a 57% 5-year survival and a 35% 10-year survival (Fig. 1). Only one patient died in the immediate post-insertion period. A post-mortem was not obtained, but cardiac tamponade was considered the most likely possibility. Late deaths occurred in 10 situations in which the pacemaker may have contributed to demise, although was not primarily responsible. This includes 2 patients with sepsis, 1 with electrode erosion and the remain-

FIG. 1—Cumulative probability of survival.



der with other complications including electrode withdrawal or cardiac arrest. (Table 4)

TABLE 4.—Causes of Death

Pacemaker related	10
Other illness	64
Surgical implantation	(1)

Discussion

The present study confirms the relative ease and safety of the transvenous approach for cardiac pacing. Our reported long-term survival compares favorably at 1, 5 and 10 years with a number of other studies.⁷⁻¹⁰

The procedure of insertion itself was followed by only 1 death (0.4% mortality), a low mortality in a group of elderly patients with a variety of other disease processes.

Electrode malfunction remains a problem, although fracture has virtually been eliminated as a cause of electrode failure. Electrode withdrawal occurred with greater frequency (23 of 40 electrode failures, 19 of 36 (8%) occurring acutely than in other series.¹¹ The decreasing use of the unipolar electrode may improve this result; over half of the electrode withdrawals occurred with a unipolar electrode which, in turn, comprised only 24% of the electrodes implanted.

A further factor in high incidence of electrode withdrawal may have been the short interval between placement of the temporary electrode and the permanent unit. A delay after placement of the temporary electrode, particularly in patients with a large heart appears to have reduced ventricular failure, particularly the size of the right ventricular cavity, which appears to be an important factor in electrode withdrawal.

Late infections have probably been the result of pacemaker erosion rather than primary infections, but in the 3 instances it was impossible to tell which came first. The acute infection incidence of 1.2% is in line with that reported by others.^{5,12,13}

The incidence of electrode or pulse generator erosion (20%) is far higher than that reported by others.^{5,10,14} Surprisingly, the complication has been managed successfully in each instance. The reason for this high complication rate is, we believe, due to the high incidence of thin Oriental patients in this series. Migration of the pulse generator contributes to this problem as well. Many of these patients, particularly in the older generations, are of short stature, slight build, very thin with minimal subcutaneous tissue. We believe that avoiding an electrode passing over the clavicle and use of smaller, lithium power sources will reduce the problem of erosion substantially in this group of patients. Use of suture fixation of the pulse generator to the prepectoral fascia and sub-pectoralis muscle placement in selected cases may have also reduced this problem in recent implantations.

In general, the series compares favorably with groups reported from most other large centers. The major areas for improvement relate to inadequate followup between 6 weeks and 24 months and an inordinately high incidence of electrode failure and skin erosion. One of the problems in a community hospital is that several

different physicians and surgeons diagnose and treat the patient. This makes for wide variations in expertise and techniques. In the present series 8 surgeons were responsible for one or more of the pacemaker implants. Currently, a centralized followup registry is being planned which should reduce followup problems. The impetus for this was provided by the erratic followup data reported herein. Furthermore, current standardization of procedures and methods may further minimize many of the observed complications with electrode failure and erosion.

In spite of a slightly increased incidence of minor complications, the present series emphasizes the safety and reliability of the transvenous approach. The only problems which might be obviated by direct myocardial electrodes relate to electrode malfunction, particularly with electrode withdrawal. However, the low acute mortality and the excellent long-term results suggest that direct myocardial electrodes cannot be implanted with as low risk and should be reserved for selected patients where the transvenous route has failed or avoidance of risks of electrode withdrawal is particularly critical.

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HIGUCHI INSURANCE AGENCY, INC.

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HONOLULU COUNTY MEDICAL SOCIETY'S INSURANCE PROGRAM ADMINISTRATOR

TERM LIFE INSURANCE

DISABILITY INCOME INSURANCE

DEFENDANTS REIMBURSEMENT INSURANCE



JON WON

Medical Assistant Training Seminar Accreditation: was recently received by Kapiolani Community College in Honolulu that the American Medical Association's Committee on Allied Health Education and Accreditation, acting in collaboration with the Curriculum Review Board of the American Association of Medical Assistants, has granted full accreditation to their Medical Assistant education program. HMA extends its best wishes for continued successful operation of this program for the preparation of personnel of the allied health team.

Hawaii Medical Assistant Elected National Trustee of American Association of Medical Assistants. Helen Torricer, LPN, CMA-AC, staff medical assistant to Dr. Varian Sloan for nearly 20 years was elected to the Board of Trustees of the AAMA at their national convention in October. As a charter member of the Hawaii Chapter of AAMA, Helen has served her professional organization in numerous capacities, culminating in the presidency in 1969. She was named Medical Assistant of the year in 1964. The AAMA is a national organization of more than 18,000 medical assistants who work under the direct supervision of licensed physicians. One of the major objectives of the Association is to increase the education and professionalism of medical assistants.

Hawaii Pay Rates Increase 6 to 8 Percent as reported in the Hawaii Employer's Council Pay Rate Survey for 1977. Physicians are reminded that the new Federal Minimum Wage Schedule provides for a minimum of \$2.65 an hour effective January 1, 1978; \$2.90 January 1, 1979; \$3.15 January 1, 1980; and \$3.40 January 1, 1981. The \$2.65 minimum that becomes effective January 1, 1978 amounts to a minimum monthly salary of \$460 for a 40 hour labor work-week.

1978 HAMPAC-AMPAC Membership Campaign Off To Fast Start during HMA's 121st Annual Meeting. Doctor Len Howard, Chairman for HAMPAC, reports that members of HMA's Auxiliary who manned HAMPAC's political education and information booth during the meeting signed up 5 sustaining and 11 regular members for 1978. Approximately 600 mainland and Hawaii physicians were registered for the Annual Meeting.



The overemphasis on certification.

4,453 physicians attended the American Academy of Family Physicians' Scientific Assembly in Las Vegas in October. Category "P" (Prescribed) credits, with criteria more stringent than those for the AMA's Category 1 for the PRA (Physicians' Recognition Award), were available for the picking. They were indeed of top quality.

The occasion was also significant in point of fact that for the first time in its 30 years of existence, the Congress of Delegates of the AAFP mustered a full complement of 122 delegates—two from each of the 50 states, and two each from the District of Columbia, Puerto Rico, the Virgin Islands, the Military, the Hospital Residents, and Medical Students.

The AAFP has long been in the forefront of the CME movement. At its inception in 1947, it incorporated into its by-laws that a requirement of continued membership be for a member to provide evidence of his having availed himself of so many hours of approved CME. Until rather recently, this was the only professional organization to require this.

The AAFP, working with the AMA, launched the ABFP (American Board of Family Practice), incorporated in 1969. This new "specialty" board, certifying physicians as specialists in Family Practice on a par with all the other specialties, jumped ahead of all the rest by requiring its diplomates to submit themselves to a re-examination for re-certification every six years. In short, the ABFP says: "Boy, once you're certified as a specialist does not mean you can coast along on your laurels *ad infinitum*! Get with it, man, and you had better keep up. Let's see if you have kept up with the times. Take another exam, boy, or you lose your certification as a specialist and you revert to being an

ordinary GP!"

Not on your life!

In the first place, to be an "ordinary GP" is no stigma. In the second place, members of the AAFP have to keep their CME status current, or at least every *three* years; diplomates of the ABFP can coast along for six years before sitting down to cram for an examination. Members of the AAFP must submit evidence of having taken 75 hours of Category "P" CME in addition to at least 75 hours of other electives, every three years. Their continued membership in AAFP is not dependent on certification by examination. The AAFP could be said to have as its motto: "If you consider yourself not too old to practice medicine, then you must not be too old to learn."

The Congress of Delegates of the AAFP urged all of its members, however, to take the ABFP certifying examinations and to get their "boards." Unfortunately, it also set a deadline, after which no physician may become eligible to take the exam unless s/he has taken a full 3-year residency in an approved Residency-in-Family-Practice. That deadline has now come and gone. The 1977 C of D voted *not* to extend it.

Interestingly, 65% of the delegates were diplomates of the ABFP, whereas only 35% of the membership of over 38,000 in AAFP have taken the boards. The action of the C of D cut off the possibility for the other 65% of the membership to become certified as specialists, or at least for those in the older age category who went into practice long before there was any such thing as a FP residency.

Will this create an unfortunate schism within the AAFP? It might.

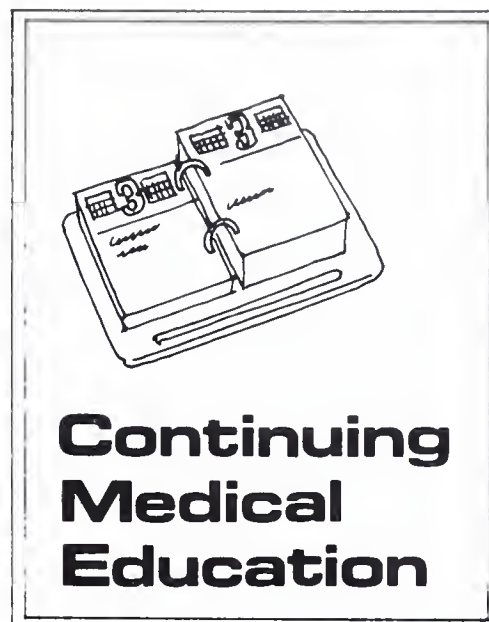
Proponents of the cut-off argued that enough time was given for all members to have made application to take the boards; that those who haven't probably never will anyway. The answer to that, of course, is: Why shut the door?

The opponents to the cut-off—the losing side—contended that to shut the door was unnecessary, unwise and selfish. They said it would set the diplomates apart as a special breed of pseudo-specialist, while in fact the diplomates were no different from the rest of the generalists, and maybe would thereby set themselves up as being "super" specialists. True, the ABFP plaque may be impressive on the office wall; but, many physicians, particularly long-time members of AAFP, can laugh at additional diplomata as simple adornment. Their patients are legion and loyal and care nothing for such fol-de-rol. True, the new label may open more doors to privileges in hospitals; but, a major lawsuit in the State of Massachusetts currently attests to there being no such thing as an open sesame to an ABFP diplomate.

There are many physicians, and not only the members of AAFP, who have kept right on "learning as they practice" and have kept abreast of modern medicine without indulging in formal CME. There are many who have all the hospital privileges they want or need in order to take care of their patients. There are many opportunities and open doors facing the young MD who is not board certified/eligible, but who will go all out to present good credentials and to prove himself competent and capable.

We can still say, within the profession, that we tend to be helpful to our colleagues and peers, rather than be restrictive, *provided* the patient is always well-protected.

JIFR



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

1. G.I. Conference, 3rd Tues., 1:00 p.m.
2. Medical Mortality & Morbidity, 4th Tues., 1:00-2:00 p.m.
3. Endocrine conf., 2nd Wed., 1:00-2:00 p.m.
4. Oncology Conf., Every Thurs., 7:30-8:30 a.m.
5. Surgical Mortality & Morbidity, 5th Fri., 1:00-2:00 p.m.
6. Visiting Prof. Programs.
7. Ophthalmology Dept. Mtg. 1st Tues., 1:00-2:00 p.m.
8. Orthopedic Dept. Mtg. 2nd Tues., 8:00-9:00 a.m.

(Contact: CME Dept.-Kuakini for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium

2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m.
(Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professors' Program.
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

St. Francis Hospital

1. Orthopedic Dept. Conf. 3rd Fri. ea. month. 7:30 a.m.-Med. Staff Board Rm.
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
7. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu

Type: I, 1 hr/day, 1 day/mo from 12 mos

Fee: None Methods: AV, O, Pan

Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

Type: I, 1 hr/day, 1 day/mo for 8 mos

Fee: None Methods: AV, Clin C, O, Pan, R

Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

Dec. 7-
Dec. 14,
1977 "Advanced Trauma Life Support (ATLS) Trauma Lab Courses for emergency physicians." 1-6 P.M. Rm. C-208, 2nd Flr. Biomedical Bldg. Schl. of Med U of HI. Contact: J.K. Sims, M.D. EMS (808) 547-4471.

Dec. 6, 1977 Diving Med.-Univ. of HI Schl. of Med. 1960 E-West Rd. Honolulu, 96822. Held at King Kamehameha Htl. on Kailua-Kona. Fee \$225.

Nov. 28-
Dec. 2, 1977 Lymphoproliferative Disorders, USC at Mauna Kea Beach Htl., Kamuela, HI. One week.

Nov. 27,
Dec. 2,
1977 "Ultrasound of the Eye and Orbit" Seminar. Waikiki Sheraton & Tripler AMC. Univ. of Iowa & Tripler. CME Cat. 1-21 credits. Contact: Philip M. Corboy, M.D. Co-ord. (808) 923-4734.

Dec. 1-5,
1977 ENG Workshop, Pacific Med. Cnts., San. Fran. Martin Brotman, M.D., Chairman. CME, P.O. Box 7999, San. Fran. 94120. Held at Ilikai Htl., Honolulu. Fri.-Sat.

Dec. 5-9,
1977 Cardiology Seminar, Hawaii Conference Services, P.O. Box 22670, Honolulu, HI 96822. Hdq. Hotel: Mauna Kea Beach. Agent: Group Travel Unlimited

Dec. 7-10,
1977 Amer. Med. Joggers Assn. 5th Annual Hono. Symposium. Princess Kaiulani Htl-Waikiki, HI. U of H Schl. of Med. & Hono. Med. Group, 550 So. Beretania St. 96813.

Jan. 9-
13, 1978 Fundamentals of Echocardiographic Interp. at Kauai Surf, Lihue, Kauai, HI. 5 days-20 hrs. Fee \$325 or non-members \$375. Amer Coll of Cardiology, 9111 Old Georgetown Rd. Bethesda, MD 20014/U of HI Schl. of Med. Hono Med. Grp.

Jan. 16-
20, 1978 Perinatal Med at Royal Lahaina Ht., Maui, HI. 5 days-30 hrs. U of So. Calif. 2025 Zonal Ave. LA, Calif 90033.

Jan. 12-
14, 1978 Gen. Pediatrics at Kona Surf Htl, Kona, HI 3 days-18 hrs. Amer. Acad OF Ped. 1801 Hinman Ave, Evanston, IL 60201.

Jan. 25-
31, 1978 3rd Annual HI Hsp. Med Staff Conf. at Kauai Surf Htl-Kalapaki Beach. Estes Prk. Inst. Box 400, Englewood CO 80151. 5 days. Fee \$190.

Jan. 25-
31, 1978 Hsp. Trustee Forum at Kauai Surf Htl-Kalapaki Beach. Estes Prk. Inst. Box 400, Englewood, CO 80151. 5 days-32 hrs. Fee \$190.

Feb. 1-
3, 1978 Post-Conf. Workshops at Htl. King Kamehameha-Kailua-Kona. Estes Prk Inst. Box 400, Englewood, CO 80151. 3 days-10 hrs. Fee \$100.

- Feb. 20-24, 1978 Advances in Pt. Care: Caring for the Older Person at Kona Surf Htl., Box 128, Kailua-Kona 96740. 5 days-31 hrs. Med. Comm. & Serv. Assn., 315 Univ. Dist. Bldg. 1107 NE 45th St. Seattle, Wash. 98105.
- Feb. 27, Mar. 2, 1978 Winter Trav. Med. Educ. Course at Royal Lahaina Htl., Maui, HI. 4 days-10 hrs. Fee \$100. Kansas City SW Clin. Soc. 2220 Holmes St. K.C., MO 64108.
- Feb. 27-Mar. 3, 1978 Clin. Mang. of Sexual Problems at Sheraton-Molokai Htl., Molokai, HI. 5 days-30 hrs. Fee \$195. Med. Comm. & Serv. Assn. 315 Univ. Dist. Bldg. 1107 NE 45th St., Seattle, Wash. 98105.
- Feb. 27-Mar. 3, 1978 Surg. Diagnosis & Therapy at Maui, HI. 5 days-20 hrs. Fee \$300. Phil Thorek Post-Grad Courses, 850 W. Irving Park Rd., Chicago, IL 60613.
- Mar. 14-18, 1978 Sports Med/Primary Phys. at Princess Kaiulani Htl., Waikiki, Hono., HI. 5 days-18 hrs. Fee \$200. U of HI Sch of Med. 1960 E West Rd., Hono 96822 & Amer Acad of Family Prac.
- Apr. 17-21, 1978 Emergency Med., 1978 at Royal Lahaina Htl., Maui, HI. 5 days-30 hrs. U of So Calif

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



Friday, August 5, 1977 HMA Conference Room

CALL TO ORDER

The meeting was called to order by President Calvin C. J. Sia. Also present were Drs. William Dang, Grover Batten, William Iaconetti, Herbert Chinn, Ann Catts, Richard Lundborg, Albert Chun-Hoon, George Goto, J.I.F. Reppun, Leonard Howard, Calvin Kam, Sakae Uehara, George Mills, and Edgar Ho. Mrs. Fred Shepard of the Auxiliary and V. Thomas Rice, HMA attorney, were also present.

MINUTES

The minutes of the July 8, 1977 meeting were approved as circulated.

REPORT OF THE TREASURER AND FINANCE COMMITTEE

A. June 1977 financial statement: The June 1977 financial statement was reviewed in detail. It was voted to approve the report subject to audit.

B. Finance Committee Recommendations: The Finance Committee reviewed two invoices for legal services relating to EMS and the Mabel Smyth Building and recommends approval for payment of the bills.

ACTION:

It was moved, seconded, and approved to approve the recommendation for payment of the legal fees.

The committee recommended that Council approve the invoices for the HMA Hospitality reception at the AMA Meeting in San Francisco.

ACTION:

It was moved, seconded, and passed to forward payment for the hospitality reception.

The committee further recommended that funds in the President's contingency fund be used for a one-day retreat of the Council on October 2 to discuss short and long-term goals for the Association in preparation for the annual meeting.

ACTION:

It was moved, seconded, and passed to approve the use of the contingency fund for a retreat.

The committee noted that it is presently working on the 1978 budget which will be presented to the House of Delegates in November and plans to circulate it prior to the next Council meeting. The committee proposed renovation to the HMA office area which will permit expansion of the office space. The alternatives for renovation of the kitchen area were discussed and it was proposed that the duplicating equipment and machine room be moved to the kitchen area and the remaining area be carpeted and drapery added for expansion of existing offices.

ACTION:

It was moved, seconded, and passed that a budget of \$2,500 be allowed for renovation of the office space and that the 1978 budget include a line item for renovation and modifications to HMA office space.

The Council reviewed several proposals relating to copying equipment in consideration of the expiration of the lease on the present equipment. The proposals included the cost figures for both lease and purchase options for two types of equipment. The purchase option offered a greater cost savings.

ACTION:

It was moved, seconded, and passed to purchase a Xerox 4500 machine under the most economical plan available.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. Rubella: The Communicable Disease Committee has continued to meet with representatives of the Department of Health regarding rubella. It was noted that all laboratories, not only the State lab, are processing the samples for rubella testing.

B. Community Health: Mr. Won reported that the State Health Planning and Development Agency is presently considering rules and regulations for certificate of need and is attempting to define an organized ambulatory care facility. Hearings will be scheduled in the near future.

MISCELLANEOUS REPORTS

A. Auxiliary: Mrs. Shepard reported that the Auxiliary is planning legislative workshops on the neighbor islands. She noted that the Auxiliary is considering a direct membership arrangement for those who wish to be members but who are no longer eligible under the present membership system.

B. HAMPAC: Dr. Howard reported that HAMPAC presently has a membership of 307, 32 spouses are members and there are 14 sustaining members. The board plans to have a booth at the HMA annual meeting and will start their membership drive at that time.

C. Legislative hearings: The Senate Health Committee has scheduled hearings regarding the use of laetrile and definition of death. The HMA was represented by Dr. Sowers at the Laetrile hearing. Dr. Siemsen will attend the hearing on definition of death.

D. Self Insurance: Dr. Sia noted that a new insurance proposal had been received and was being reviewed by Dr. Edwards and the Self Insurance Committee.

E. Bureau of Research and Planning: The Bureau is continuing to explore the feasibility of a Diabetes Center and has asked Dr. Rose Wong to consider serving as the project director.

F. Cancer Committee: Dr. Condit has resigned as chairman of the committee for personal reasons. Dr. Sia noted that the CBCCP under the Cancer Center has received their grant award for a five-year period. He noted that he has asked to meet with the director of the Center as well as the President and Chancellor to again clarify the relationships between the HMA, University of Hawaii; and the Cancer Center. He announced also that the groundbreaking for the Cancer Center Building will be held on August 14.

G. Invitation from Hiroshima Medical Association: Dr. Sia noted that the HMA President and members of the Council have been invited by the Hiroshima Medical Association to visit them in Japan at their annual meeting which is to be held in November. The President of the Hiroshima Association visited Hawaii earlier this year and expressed the interest of his association in establishing a sister relationship with the HMA. It was agreed that resolutions to this effect would be exchanged. A representative from the Hiroshima Medical Association visited the HMA several days ago to ensure that HMA representatives would accept the invitation that has been extended.

ACTION:

A motion was made and seconded to approve the expenditure of HMA funds for the purchase of two round-trip tourist class airline tickets to Japan in order that the current President and Executive Director of HMA, or their designees from the HMA membership or staff respectively, may attend the annual meeting of the Hiroshima Medical Association in November 1977 in order to represent the HMA. The motion was amended to include the president-elect of HMA. The motion passed.

A resolution for presentation to the Hiroshima Medical Association was adopted as follows:

WHEREAS, the Hawaii Medical Association, Honolulu, Hawaii, and the Hiroshima Prefecture Medical Association, Hiroshima, Japan, have both acknowledged their mutual interest and desire in establishing a relationship between the two organizations; and

WHEREAS, the Hawaii Medical Association holds the Hiroshima Prefecture Medical Association, its officers and members, in high esteem; and

WHEREAS, the Hawaii Medical Association wishes to strengthen friendly relations with and exchange information of mutual interest with the Hiroshima Prefecture Medical Association; and

WHEREAS, the Hawaii Medical Association wishes to uphold the highest honor of the medical profession with its colleagues in Hiroshima, Japan; now therefore be it

Resolved, that the Hawaii Medical Association conclude a sister medical association affiliation with the Hiroshima Prefecture Medical Association.

H. Pacific PSRO: Mr. Won reported that the HMA Council and PSRO Board had adopted the position of sharing office space, personnel, and equipment. PacPSRO is growing rapidly and has required additional office space within the facility as well as increased staff. The PSRO Board would like to remain closely allied with the HMA and requests that the Council comment on this relationship.

ACTION:

It was moved, seconded, and approved that the relationship between HMA and PSRO for sharing office space, personnel and equipment be continued.

I. Disaster Committee: The HMA Disaster Committee will participate in a community disaster exercise scheduled for October 12.

NEW BUSINESS

National Health Insurance: The AMA House of Delegates and the Louisiana State Medical Society have called for statements from all state medical associations regarding their position on national health insurance. Dr. Mills presented a comprehensive report on the AMA bill and noted that in essence the AMA bill is a substitute for the prepaid health plan that presently exists in Hawaii. Several members of the Council expressed their concern that the coinsurance should apply to everyone who enters the system even though the amount paid is only token.

ACTION:

It was moved, seconded, and passed that the HMA Council support S 218 and HR 1818, the AMA-sponsored bill on national health insurance.

ADJOURNMENT

The meeting adjourned at 9:00 p.m.

DOUGLAS B. BELL II, M.D.
Secretary



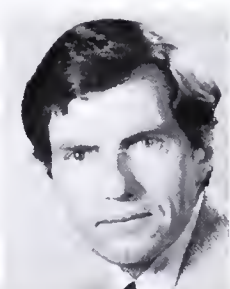
"He looks like you, Harold."



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Honolulu, Hawaii 96817
INTERNAL MEDICINE



Jose C. De Leon, M.D.
98-1247 Kaahumanu Street
Honolulu, Hawaii 96701
INTERNAL MEDICINE



James Roy Doyle, M.D.
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Thomas Y. Ito, M.D.
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Hawaii Academy of Family Physicians' Newsletter

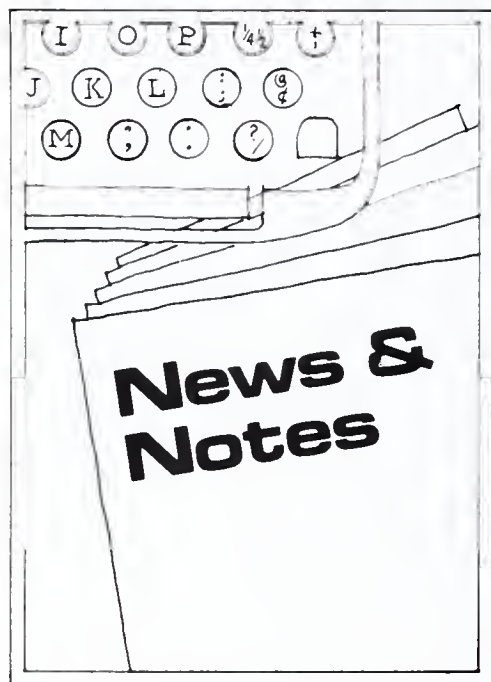
J. I. FREDERICK REPPUN, M.D.

News of Members—Present at the AAFP meeting in Las Vegas in October were members **Cahill, Kern, Lafferty, Reppun** and **Larry Wong**, as far as we know. If any others from HAFP were there, please let us know. **Pat Dietrich**, our secretary, was featured in the Star-Bulletin of 21 October in an article by Tomi Knaessler, well-known medical reporter who won the annual Hawaii Medical Ass'n Award for 1977. Tomi described the rapprochement between Medicine and Chiropody in the husband and wife team of Dietrich MD and Dewey L. Shaak, Chiropractor. **Tom Cahill** served as chairman of the Reference Committee on Miscellaneous Business at the HMA's 121st Annual Meeting of the House of Delegates early this month. **Arch Wigle** from the Big Island and **Felix Lafferty** from Honolulu were elected Councilors to the HMA for 1978 and 1979. Felix unfortunately lost his bid to be elected a Director to the Board of the AAFP. **Fred Reppun** sat as a member of the AAFP Reference Committee on the Reports of Officers and Committees.

AAFP 30th Annual Meeting in Las Vegas—Both of *Hawaii's resolutions* were shot down by the Congress of Delegates: The one attempted to allow physicians who return for a year or more of residency refresher training, after being out in practice, to maintain their Active status and receive automatically the maximum of credit hours. The C of D decided to keep the old ruling that forces that member to become "Inactive" and have his credit requirement waived. The other attempted to allow Hawaii's Education chairman to send applications for approval of courses for "P" direct to Hq in Kansas City, mainly because of the inordinate delay in having the Form #102's returned from the regional chairman on the West Coast. No other state chapter

seems to be having this trouble! The AAFP came up with a dedication to further *self-assessment examinations*, based on a 6-year core curriculum, as the wave of the future in CME. It also promised itself to do all it could to help promote *patient education* in health and disease, as the best way to lower the nation's escalating costs of health care. The AAFP reiterated its belief in *quality control* rather than *cost containment* as regards American Medicine's future, and stood by its principle re National Health Insurance: **"Our country cannot afford, nor does it need, federally administered comprehensive national health insurance."** As for *privileges* for family physicians in hospitals, the AAFP is working with the JCAH in the formation of Family Practice Departments in hospitals as full clinical depts.; such a dept. will pass on the privileges granted its member, in consultation with the dept. wherein the member is asking for privileges. The AAFP recommends that no physician prescribe or administer *Laetrile* until its efficacy and safety have been proven scientifically.

CME—We still have not received word as to the category of credit to be allowed for the Pan-Pacific Surgical Ass'n 14th Congress in Honolulu next April 1-7, 1978. The Honolulu Marathon Ass'n is offering the Fifth Annual AMJA Symposium 7-10 Dec 77 at the PK for 20 credit hours "P". Don't forget the HAFP Scientific Session on 21 & 22 Jan 78, and the annual dinner meeting on 21 January!



Life In These Parts

An 80-year-old Japanese woman with recurrent left mid quadrant post-evacuation pain was being evaluated. As we started to proctoscope her, we asked our trusty nurse if the Fleet enema had worked. "She isn't too sure . . . She forgot to take the cap off the tube and when she remembered, she couldn't find it . . ." Just then at 10 cm from the anal verge, we located the recalcitrant cap, sparkling lemon green against the residual Fleet enema . . . Well, at least she didn't drink the fleet enema like another patient or insert a Dulcolax suppository with the aluminum foil on . . .

When someone wrote: "Dear MS FIXIT: HMSA seems to have a double standard. Allowable amounts for patients of doctors participating in HMSA are more than for nonparticipating doctors. Why the discrimination? HMSA replied: "HMSA plans provide for a free choice of physician and therefore, it is the member who decides from which physician to obtain services." "In order to provide our membership with

the full guaranteed benefit of their particular plan, HMSA has 'participating agreements' with many of Hawaii's physicians. The participating physician agrees to accept HMSA's determination of a reasonable charge for services rendered. The participating physician further agrees not to pass on any additional charges."

"A nonparticipating physician does not have a signed agreement and, in these cases, HMSA will reimburse the member the full plan allowance toward a reasonable charge. Any difference between the charge and HMSA's allowance is to be settled between the physician and the patient.

"Since physician fees vary considerably, we recommend members get in touch with HMSA's Customer Service (944-2272) if you have a specific problem. They will be happy to help you." (Guess we missed the answer to the question somewhere in the above verbiage.)

Honolulu is ranked as the 7th best city in the U.S. to live in according to the Oct. 18 issue of Family Circle . . . The criteria are clean air and water, medical, recreation and housing facilities, unemployment and crime rates, cultural amenities, and diverse night life . . . Daacon in his column also adds that Honolulu ranks 2nd in health care and "has more dentists per capita than anywhere in the world." (Lucky we live Hawaii . . .)

Stephen Aglinskas and HEPA are suing lawyer Edwin Smith and the elderly couple who sued him over a year ago . . . Stephen was sued for allegedly giving improper emergency care to 75-year-old Mrs. Callender at Hilo Hospital, but the case was dismissed by the Third Circuit Court last May. Bernard Scherman, president of HEPA, contends, "Doctors are responsible for their errors so lawyers must be responsible for their errors too."

Katsuhiko Yano, associate director of the Honolulu Heart Study, reports that the incidence of coronary heart disease is lower among Hawaii Japanese born in Japan than those born here. Oddly and inexplicably, the longer the Hawaii Japanese have lived in Japan, the less the chance of having heart disease. Katsuhiko also reports that the rate of coronary heart disease among Hawaii Japanese is twice the rate for Japan Japanese and the rate for California Japanese is 50% higher than for Hawaii Japanese . . . He feels that Hawaii Japanese who have lived longer in Japan "learn something in Japan . . . A Way of Life—and it's not explained by diet but perhaps by psychological or personal factors." Katsuhiko also says that moderate drinking (3 beers a day), appears to benefit people susceptible to heart disease . . . ie, moderate drinking increases the alpha factor (usually 25% of blood cholesterol) which opposes the beta factor (usually 75% of blood cholesterol). The alpha factor apparently acts to protect against heart disease . . . Another Yano quote is that coffee in moderation is not harmful . . . William Kannel, director of the Heart Disease Epidemiology Study at Framingham, Mass. in the May 25, 1977 issue of the New England Journal, commented on the Honolulu Heart Study report: "It is encouraging to note that not everything one enjoys in life predisposes to cardiovascular disease. There is nothing to suggest, for the present, that we must give up either coffee or alcohol in moderation to avoid a heart attack."

When *Advertiser* columnist Daacon ran a contest for the most unusual/effective way of conserving water, Florence Chinn Loui suggested washing the floor, sinks, and tubs less often . . . and that all condominium units have individual water meters so people won't waste because it's included in the maintenance fee. . . .

Jim Penoff beams that there'll be more fellow plastic surgeons in town than you can shake a scalpel at when the Pan Pacific Surgical Conference meets here in April." (Daacon)

In October at a meeting conducted by representatives of the U.S. Dept. of HEW, State Health Dept. director George Yuen told the Federal officials that the Ariyoshi Administration agrees with the concept of national health insurance, provided it will not raise the price or lower the quality and scope of health care now available to island residents . . . George recommended that any Federal health insurance act should: Provide universal and mandatory coverage to all U.S. residents, including nationals, aliens, and immigrants; provide federal funds for health services to immigrants, includ-

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ing the hiring of bilingual personnel; empower states to enact their own health insurance legislation in compliance with Federal guidelines.

National Health Insurance is supposed to provide adequate coverage for the estimated 26 million persons nationally who have no insurance either through private or public programs; enhance the coverage of some 25 million persons inadequately covered by private insurance plans and protect them against catastrophic medical expenses; and remedy the problems and inadequacies of health care of the poor and aged now covered by Medicaid and Medicare. (HEW says the present Medicare program pays less than 40% of the health costs of the elderly . . .)

The Hawaii Nursing Home Ombudsman program went into effect in July, implemented by the HCAP (Honolulu Community Action Program) and administered through the Executive Office on Aging. Every patient in one of Hawaii's 18 intermediate care or skilled nursing facilities should have read and signed the Patient's Bill of Rights (which informs the patient of his medical condition and gives him the right to participate in the planning of treatment; gives the patient the right to vote, get married or divorced, acquire or dispose of property, and practice his own religion). The patient also has the right to voice grievances, is entitled to privacy and the right to be treated with respect and dignity. The Hawaii Nursing Home Ombudsman Program is an outgrowth of a Federal ombudsman program established by the HEW . . .

SID (Sudden Infant Death) formerly known as "Crib Death" is being investigated in Hawaii by a three-man team: **David Crowell**, a biomedical researcher at the U of H Pacific Biomedical Research Center and director of the Newborn Laboratory at Kapiolani, who is checking on metabolic causes—esp. the relation to sleep; **Scott Halstead**, chairman of the U of H Med. School's Department of Tropical Medicine, who is pursuing the virus infection theory; and **Dexter Seto** who is studying the possibility of allergy to virus as being the cause . . .

Whitney Expedition III (a 250-mile trek around Maui on foot and horseback) set out from Kaneohe Yacht Club on a 41-foot interisland Sloop Ekuke for Maui. *Advertiser* columnist Bob Krauss described one hardy physician's travails: "**Dr. Charles Judd**, surgeon, power canoe paddler, sturdy mountain climber, was flat on his back on the starboard side, his face the color of a tombstone . . ." (Ed: We've known that feeling, Charley)

Ralph Nader's Health Research Group released a list of 19 clinics and hospitals where the group claims breast cancer detection programs led to incorrect diagnoses and in some cases, unnecessary surgery. The list also included the Pacific Health Research Institute, Inc. of Honolulu which the Nader group claims four incorrect diagnoses of breast cancer were made . . . Sidney Wolfe, head of the group, urged the NCI to "establish a surveillance system which assures that all diagnostic findings of benign tumors or minimal cancers by referral hospital pathologists are reviewed by a second, impartial pathologist before a final diagnosis is made or any mastectomy is performed." (Ed: Who is then to review the opinion of such peers? We have yet to meet an infallible super pathologist and never expect to meet one in our life time . . .)

Eberhard Mann of the Children's Hospital crisis center feels that incest is perhaps the most underreported family problem in Hawaii . . . Of 106 sex abuse cases involving children between July 1976 and June 1977, 31 of them were "family related." And he feels that this is "just the tip of the iceberg." Of the 106 reported cases, 39% involved part-Hawaiians and 39% Caucasians, 9.4% Filipinos, and 4.7% Japanese. Eberhard reports, "Very few cultures accept father-daughter incest . . . The old Hawaiian culture accepted incest between brothers and sisters, but that was a class thing. And they did not accept incest between father and daughter."

Embarrassing Moments

During a Kuakini quarterly staff meeting, OB man **Harry Nakata's** beeper suddenly came to life with the following

urgent message: "Dr. Nakata . . . Call Radio Call immediately! You have an angry tenant!"

Physicians and Art Exhibits

Somehow those personal invitations to art exhibits find their way to our home and we were dragged along to two recent exhibits . . . The first was a showing of abstracts by **Minoru Kimura's** brother . . . Orthopedist **Richard Kimura** was there and surgeon **Jim Nishi** purchased a fine sketch for his wife Lillian . . . We honestly tried hard to understand the formless forms and the incomprehensible symmetry and color patterns and failed . . .

Then one lovely Sunday afternoon, we had to attend Bumpai Akaji's exhibit of 40 or more metal sculptures at a private Manoa home. "You are cordially invited to share this experience," the invitation read. Well, we could at least recognize the skeletons and birds and the colors were brilliant . . . During the ½ hour we viewed, with subdued awe, **Gene** and **Cecilia Doo** and **Worldster** and **Patricia Lee** also came and viewed . . . We were impressed by the two large metal mosaics purchased by **Dick Mamiya** for his office . . . The colors were dazzling and the prices equally so . . . Guess we just don't qualify as a patron of the arts . . .

Elected, Appointed & Honored

The American Lung Association of Hawaii awarded grants to the following local researchers: **George Read** of the U of H to study a new group of histamine inhibitors for treating hay fever and asthma; **D.G. Massey** and **Gisele Fournier-Massey** to develop a diagnostic test to define asthma; **Francis Pien** to study results of TB drug susceptibility testing in Hawaii from 1955 to 1977 in an effort to develop statistical data on TB drug resistance; **Bert Lum** for a study on "Bronchodilator Drugs and Cyclic AMP."

On Maui, **Bertram Weeks** was selected chairman of the 1977 Ka Lima Fund Drive (the Maui Rehabilitation Center) which is targeting for \$25,000.

The American Cancer Society of Hawaii Division installed **Richard Wheeler** succeeding **Reginald Ho**, elected **Carl Boyer** a national delegate, and **George Bracher** and **Donald Dietrich** and **Roberto Labalan** new board members. The Maui Unit elected **Donald Dietrich** as president and **Russell Stodd** vice president. The Kauai Unit, with **W. W. Greene** as outgoing president, elected an all-woman slate of new officers . . .

Professional Moves

The deluge continues into October: Into the Queen's Physicians' Office Building moved the Colo-Rectal Clinic, Inc. of **Dick Omura** and **Clarence Sakai**, surgeon **Albert Chun**, **Jose Madamba**, gastroenterologist **Gary Glover**, OB Gyn men **Gail Li** and **Theodore Tseu**, surgeon **Shun-Kwong Liao**, **James Doyle** joining the Orthopedic Associates of Hawaii, Inc., and **Chao H. Chen**. The Straub Clinic added the following: **Norman Nakashima** in Acute Care/ER, plastic surgeon **Robert Schulz**, OB Gyn man **Gareth Yokochi** who will cover the Aiea Office and anesthesiologist **Joseline Brestle**. Into the Kapiolani-Children's Hospital moved plastic surgeon **Gunther Hintz**. The Kaiser-Permanente Medical Care Program added psychiatrist **Brian W. Koch** and **Karl Pregitzer** (in emergency medicine). Internist **Dennis Meyer** joined **Max Botticelli** and **Christian Gulbrandsen** at Room 100 Harkness Pavilion. Oncologist **John Keenan** opened a Medical Oncology Clinic at the Fronk Clinic Pearlridge, ophthalmologist **Percival Chee** relocated to Suite C116 Kukui Plaza Mall, 50 So. Beretania St. and GP **Joseph Battista** opened his office in the Wahiawa Business Center, 302 California Ave. In Haleiwa, **Thornton Dilcher** joined **Rodman Miller** at the Haleiwa Medical Clinic, Inc.

On the Big Island, general surgeon **Guy Terrell** associated with Kona Medical Associates, Kailua-Kona, and GP **Jeffery McDevitt** opened at the New Kealahakua Post Office Building and on Maui, psychiatrist **Douglas Cooper** opened his office at 55 Makawao Ave., Pukalani. On Kauai, OB Gyn man **Larry Dotson** will have offices in Waimea and Eleele, while



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internist **John Gilmore** joined the Waimea Clinic, Inc. Daacon's grapevine reveals that **Jack Scaff** and **John Wagner** have purchased a condo in the Kukui Plaza for their medical office to be opened in January.

We were happy to see **Paul Gebauer** back as acting City Physician. The position was vacated by Paul when unfair charges of petty politics and mismanagement caused him to quit in protest. **Sam Yee** then filled the vacancy for several months and quit for health reasons. **Benjamin Lambiotte** took Sam's position and then resigned . . . for reasons undisclosed . . .

Hors De Combat

Fred Goff with the Waimea Medical Clinic was beaten and robbed of about \$5,000 worth of valuables at his Waianae home by two men entering around 9:35 pm on Oct. 7.

The U.S. has about 175 physicians per 100,000 population, placing it behind Israel, the Soviet Union, Italy and West Germany in the per capita supply of doctors. By 1990, the U.S. will have anywhere from 225 to 240 or more physicians per 100,000. In 1971, acting to meet an estimated shortage of 50,000 physicians, Congress increased medical school openings from 9,000 to an estimated 16,000 by 1979. By 1976, the pendulum had begun swinging the other way and the Carnegie Council on Higher Education warned that we were in serious danger of developing too many medical schools. Congress also moved to restrict the entry of foreign medical graduates. In 1976, the U.S. spent \$139.3 billion, about 8.6% of the gross national product on health care. At the current rate of increase in spending, the country will be spending \$243 billion annually by 1980, in excess of 10% of the gross national product. The Federal health policymakers, who have been struggling for years with an oversupply of hospital beds, are now becoming concerned that they may soon have another costly problem on their hands: too many doctors.

Protesting doctors at Hilo Hospital have succeeded in getting the State to reduce its planned rate increase from 51% to 34%, but are still unhappy. They feel that the issue is quality medical care and they feel a new acute care hospital is needed.

Under an FDA order, druggists who fill prescriptions for the estimated 5 million American women taking estrogens must warn customers of the risk of developing cancer of the uterus as well as other cancers of the breast, cervix, vagina and liver. Early in October, a federal court overturned objections by the Pharmaceutical Manufacturers Association and the American College of Obstetricians and Gynecologists that attempted to delay the requirement, but legal challenges still exist in other federal courts.

An ongoing study of 46,000 women in Britain since 1968 has shown that pill users face a 40% higher death rate than women of the same age who never used the pill. All the excess risk was attributed to an increasing number of deaths from circulatory diseases, ie, heart attacks, high blood pressure, blood clots, strokes and hemorrhages. The findings show that women who used the pill continuously for 5 years or longer had a death rate nearly 10 times higher than nonusers and more than 3½ times greater than women who were on the pill for less than five years. For women between ages 15 and 35, the deaths attributable to pill use were 5 per 100,000. For women aged 35 to 45, this increased to 34 per 100,000 and for women aged 45 to 50, 143 per 100,000. The Royal College of Obstetricians and Gynecologists is recommending: No change in pill use for women under 30; No change in pill use by women aged 30 to 35 unless they have used the pill for 5 years or longer and they smoke cigarettes, in which case they either stop smoking or find another contraceptive; and reconsideration of pill use by all women over age 35.

Doctors who only treat Medicaid patients charge lower fees and earn less money than colleagues who treat few such patients, according to an AMA survey. In 1974, those treating mostly Medicaid eligible patients earned an average of \$51,283 while those treating less such patients had an average net income of \$53,142. Medicaid physicians reported an average of 139.6 patient visits per week while non-Medicaid physicians averaged 128 visits per week.

HMSA says the \$84 million budgeted for Medicaid this

fiscal year will not be enough because of rising doctors' fees and a jump in the number of claims. HMSA claims that the number of physicians and dentists collecting more than \$50 thousand under the program more than doubled and also reported that more than 10% of the state's population was covered for Medicaid as of June.

Miscellany

Paul Condit, our friendly Oklahoman oncologist says, "Any army recruit can count to 21." (End of joke?)

A Scot highlander was asked, "What's worn under your kilt?" He replied rather indignantly, "It's just as good as ever." (Also a **Paul Condit** joke . . .)

A rare white female gorilla was captured in the heart of the Congo and brought back to the Bronx Zoo where she was a feature attraction . . . The zoo director decided to find a mate so she could reproduce more white gorillas, but on checking with zoos all over the world, there was nary a white male gorilla to be found. He finally advertised as follows: "\$10,000 for mating with our white female gorilla." A few days later, a huge hairy fellow walked into his office as an applicant, but asked that 3 conditions be met. "First, I don't have to kiss her." "Yes, that's not necessary." "Secondly, any kids born will be raised as strict Catholics." The zoo director agreed and asked, "What's your third condition?" "You have to give me 2 weeks to raise the money." (As told by **Bernie Fong** . . .)

Oncology Rounds

A 71 year old man had extensive resection of a Lt colon adenocarcinoma Duke's C with metastasis to the bladder dome . . . It was generally agreed with oncologist **Kevin Loh** that chemotherapy was the next agenda, but the prognosis looked bad. Moderator **Quint Uy** (knowing of pathologist **Grant Stemmerman's** penchant for blaming cigarette smoking for most cancers) grinned impishly and asked, "Some time ago, I saw figures that showed that this tumor was associated with cigarette smoking." Stemmy replied quickly, "This is not a tumor associated with smoking cigarettes, but there has been a suggestion that cigar smoking may be associated . . . Well cigar smokers are associated with higher incomes and social gradients so that may be the association . . ."

A 30 year old Japanese man had surgery for early adenoCA of the stomach. Kuakini pathologist **Takuji Hayashi** was enthralled: "The diffuse type CA is usually in a young female . . . This is an important case for us. . . ." For many years, **Dr. Stemmerman** has felt that hydrocortisone works on diffuse type CA which has a high binding capacity for hydrocortisone . . . A patient in another hospital with diffuse type CA who is on prednisone therapy is feeling well and eating well . . . The intestinal type CA does not have high hydrocortisone binding. . . ." Radiotherapist **Carl Boyer** was skeptical: "I don't understand . . . How does hydrocortisone binding stop the tumor?" Hayashi: "We don't really understand either . . . This is a peculiar phenomena . . . There is evidence that the tumor cells themselves are binding hydrocortisone . . ."

An 81-year-old man with a 3 month history of weight loss, anemia, had an ascending colon and cecum carcinoma per barium enema. At surgery, he had a right hemicolectomy and the pathologist described the lesion as an adenocarcinoma of the cecum, Duke's C. Pathologist **Lee** described the gross lesion: "It was 10 inches long and one out of 24 nodes was positive . . ."

Radiologist **David Sakuda** described the BE picture: "It was a long constricting apple core lesion." Oncologist **Kevin Loh** added: "The tumor was stuck to the ovary. We don't know if any adjuvant therapy helps in colon carcinoma."

Moderator **Quint Uy** tried to drum up discussion: "How accurate are upper GI's as compared to barium enemas?" David: "Colonic tumors are polypoid and therefore easier to detect, whereas gastric lesions are flat. Therefore, even if the UGI is negative, the patient should have gastroscopy. Conversely, the barium enema is a very sensitive exam." Colonoscopist **Bob Rose** disagreed: "In New York, the miss rate is 35 to 50% in colon lesions . . ." David: "I agree there are certain

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in respiratory passageways by preventing
productive and less frequent
— /5 ml

- the difficulty
- help clear the lower respiratory tract
expectorant in the U.S.*
- Guaifenesin, NF**
- Enhances output of less viscous secretions
 - Relieves irritated membranes
 - Makes dry, unproductive cough more productive
- Phospho

Codeine Phosphate, USP 10 mg/5 ml

- Pseudoephedrine HCl, NF** 30 mg
- For accompanying nasal congestion —
- An orally effective nasal/sinus decongestant.
 - Relieves congestion, reduces edema, promotes drainage.
 - 60 mg pseudoephedrine in a 2-teaspoonful adult dose
- Available in pints only. You prescribe the quantity.
8. Therapeutic Index, Jan.-Dec., 1976 IMS Annual
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uces severity, frequency and patient
omotes patient comfort.
Low drug dependence and little risk of side effects.

For accompanying nasal congestion — **30 mg/5 ml**

Pseudoephedrine HCl, NF

- An orally effective nasal/sinus decongestant.
- Relieves congestion, reduces edema, promotes drainage.
- 60 mg pseudoephedrine in a 2-teaspoonful adult dose.

Available in pints only. You prescribe the quantity dispensed.

References:
1. Medical Disease & Therapeutic Index, Jan.-Dec., 1976 IMS America Ltd., Am.
2. J. Pharm. Assn. - Dept. of Drugs, A.M.A. Drug Evaluations, 2nd Edition, Pub.
1973, pp. 482-3

NF 100 mg; Pseudoephedrine Hydrochloride Syrup, 1.4 per cent. CONTAINS 1.4% PSEUDOEPHEDRINE HYDROCHLORIDE. For use with inhaled irritants. CONTRAINDICATED in patients who are receiving MAO inhibitors or who are taking an MAO inhibitor within 14 days of the last dose. In patients with high blood pressure, should be used with caution.

Available

References:
 *National Disease & Therapeutic Index, Jan.-Dec., 1976 IMS America Ltd., Ambler, Pa. 1976
 †Amer. Med. Assn., Dept. of Drugs, A M A Drug Evaluations, 2nd Edition, Publishing Science
 Acton, Mass., 1973, pp. 482-3

Guaifenesin, NF 100 mg; Pseudoephedrine Hydrochloride, 1.4 per cent. INDICATIONS:
palatable, aromatic syrup. Alcohol, 1.4 per cent. CONTRAINDICATIONS:
 common cold or with inhaled irritants. MAO inhibitors or
 or in patients who are receiving another drug for
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 this product should be administered
 in patients with prostatic hypertrophy
 drowsiness, dizziness or sleep
 shown to produce a
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References:
National Disease & Ther.
† Amer. Med. Assn., Dept. of
Acton, Mass., 1973, pp. 482-3

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blind areas esp. in the sigmoid, but for polyps, they are much easier to detect.” Bob injected: “In Tokyo, their pictures are incredible . . .” Quint asked quietly, “Incredibly bad or incredibly good?”

Sportsmen’s Night

Sports events chairman and MC **Andy Morgan**, with his characteristic drawl, introduced the guests in order of their importance. First acknowledged was AMA President **John Budd**, then HMA prexy **Cal Sia**, AMA delegate **George Mills** and finally “a character who came back from Oregon, **Tom Thorson**.”

The first tournament chairman called was **H. Yokoyama** who reported briefly on the HMA Skin Diving Tournament held at Kalaupapa the weekend of Aug. 20-21. Unfortunately, this event is limited to 8 participants and this year, there were only a few of the regulars . . . The participants included a mountain climber **Ed Quinlan**, a fearless shore fisherman **George Suzuki**, and bow and arrow hunter **Bill Davis**. The skin divers were **Tom Cashman** (really a scuba man) who caught a few, **H. Yokoyama** who got 3 lobsters (the largest a 6-pounder, but smaller than the 7-pounder caught the year before by **Bill Moore**, **Roger Ogata** who preferred to spin for fish (unsuccessfully this year), **Marc Schlacter** who got his share of Uhu and Kumu with an 8-foot spear gun he acquired in Micronesia; but it was a tall friendly pharmacist named Harry Bjoenson who free dives to 40 feet plus who came up with the mostest and largest and left the fish for the Teruo Ogawa’s of Kalaupapa who annually host the event . . . The lobsters were speared because the diver is allergic to wana infesting their lairs and were eaten by all with gusto with the steaks and beer . . .

(Mid Pac CC 10/31/77)

Phil McNamee substituted for Ping Pong Tournament chairman **Franklin Young** in making the presentations. It seems that **Phil** and **John Spangler** teamed to win the perpetual trophy for the 2nd year in a row. Runners-up were **Joseph Young** and **Franklin Young** and in 3rd place were **Dennis Maehara** and **S.K. Liao**. The singles matches were won by **John Spangler** with **Phil McNamee** runner-up and **Joe Young** 3rd . . .

Fishing Tournament chairman **Andy Morgan** blamed the poor catch this year on “the wrong tide, the wrong time and wrong moon.” **Jim Marnie** had **John Peyton** on his boat, **Dick Sakimoto** had 3 participants on his Kamome, **Harold Sexton** had **Mits Suzuki** on his boat and **Andy** had 3 other eager fishermen on his own boat. First prize was won for the 2nd year in a row by **John Peyton** who last year landed a marlin, but this year settled for a measly 14 lb. Kawakawa. Anyway he received the perpetual trophy to keep. 2nd place was **Mitsu Suzuki** with an 8 lb. Kawakawa and 3rd place was **Ted Tseu** with a 5 lb. Kawakawa. **Mits Suzuki** also caught a baby Ahi (a mighty 2-pounder) and described the raptures of viewing the dolphins and birds off Molokai where they had anchored overnight . . . Other successful fishermen were **Tom Kobara** with a couple of even smaller Kawakawa and **John Corboy** . . . We learned that John is an avid fisherman and holds a world’s record for something.

Next came the awards for the Tennis Tournament co-chaired by **Worldster Lee** and **Dennis Maehara**. With 17 entered, the singles tournament was played over a 4-week period. The consolation bracket was won by **Noberto Baysa** with **Charley Ching** runner-up. The tournament was won by **Ben Chang** with **Dennis Maehara** runner-up. **Ken Kern** was 3rd and **Worldster Lee** 4th. The doubles tournament was played over the past weekend with 16 doubles teams entered. The top 8 teams played off on Sunday. In 4th place was the team of **Jeff Sol-Noberto Baysa**; in 3rd was **Worldster Lee-Ken Kern**, and in 2nd was **Niall Scully-Jerry Dericks** (a real ringer, we understand), while in top place was the team of **Ben Chang-Dennis Maehara**. (Ben Chang’s win in both the doubles and singles tournaments is even more remarkable since Ben had surgery for colon CA (fortunately, Duke’s A) in March this year and had just fully recovered from a postop wound abscess). Chairman **Worldster Lee** acknowledged the

contributions by Path Associates and Accupath. Outgoing HMA president **Cal Sia** presented **Yutaka Yoshida** with the original Perpetual Trophy which Yosh and **Leabert Fernandez** had won annually for the past 10 consecutive years. Cal had donated a new Perpetual Trophy. We were sad to see the Yoshida-Fernandez combo finally capitulate to youth after winning all these years and we suddenly felt old and tired . . . But it must be mentioned that Florence Fernandez recently gave birth to a 7-lb. baby girl so there is still hope that this duo (whose combined ages total 129 years) will make a comeback next year with renewed vigor).

The Golf Tournament was supposed to be chaired by **Herb Takaki**, last year’s winner, but **Bill Dang** graciously handled everything for Herb (As you probably know, Herb is 75, practices full time, is blind in one eye, drinks 12 cups of coffee, smokes 6 packs of cigarettes daily, and uses a D8 driver). Bill first thanked **Paul Tamura** and **Tom Kobara** for their generous contributions to the tournament and told the joke about the golfer and the nun. It seems that a golfer joined a golfing nun on the first tee. On the first green, he missed a 1-foot putt and exploded with “Damn it! Missed!” The nun was shocked and warned, “If you ever swear again, God will strike you with a bolt of lightning.” Everything went smoothly until on the 18th hole green, he missed another 1-footer. Forgetting the warning, he swore, “Damn it! Missed again!” Suddenly the skies darkened with rolling thunderclouds and down came a bolt of lightning which struck the nun dead . . . A voice thundered from up above, “Damn it! Missed again!” Bill’s story was supposedly prompted by **Paul Tamura** who on the 16th tee had the longest drive of the day, a 2-incher which trickled off the tee after a mighty whiff. (Now we know Paul is a minister’s son and could never, never have yelled “Damn it!”, so we know Bill is fibbing).

The Guest Flight winner was drug agent Roy Tanabe who received the **George Mill’s** perpetual trophy. **Roy Shimomishi** was 2nd with net 70 and **Jeff Lau** was 3rd with net 71.

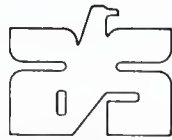
Al Chun Hoon was overall winner with a gross 76 and net 64. Al decided to keep the low gross prize and the perpetual trophy. A trio of **Al Paraz**, **Manuel Abundo** and **H. Yokoyama** had net 68’s. The rules committee has rules. In case of a tie, the winner is the lower handicapper. Al Paraz and H. Yokoyama both with 14 handicaps beat Manuel with his 16 handicap. The next cardinal rule of the rules committee is that the low net on the first nine wins. So Al Paraz with a first nine net of 40 beat H. Yokoyama’s net 43. But then **Don Lau**, our Dorsey man and partner, brought out the fact that H. Yokoyama really had a net 39 since we had started on the 10th tee. **Jim Harrison** and **Doug Bell** also in our foursome argued this fact. Now, thanks to these well meaning souls, H. Yokoyama became low net winner and tournament chairman for the following year . . . So lucky Al Paraz became 2nd and Manuel Abundo 3rd. In 4th place was **Glenn Kokame** and in 5th place **Bill Dang**, both with net 69’s . . . **Don Maruyama** was 6th, **Henry Fong** 7th & **Clifford Chang** 8th (all net 70’s).

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50 mg.
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better life for the epileptic**

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may be the start of a better life for the epileptic

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(For full prescribing information, see package circular.)

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ACTIONS: MYSOLINE acts on the central nervous system to raise seizure threshold or alter seizure pattern. The mechanism(s) of action of anticonvulsant drugs is not known.

Primidone has anticonvulsant activity *per se*. In addition, its two metabolites possess anticonvulsant qualities. The major metabolite is phenylethylmalonamide (PEMA); the other is phenobarbital. In addition to its own anticonvulsant potential, PEMA potentiates phenobarbital.

INDICATIONS: MYSOLINE, either alone or used concomitantly with other anticonvulsants, is indicated in the control of grand mal, psychomotor, and focal epileptic seizures. It may control grand mal seizures refractory to other anticonvulsant therapy.

CONTRAINDICATIONS: Primidone is contraindicated in: 1) patients with porphyria and 2) patients who are hypersensitive to phenobarbital (see ACTIONS).

WARNINGS: The abrupt withdrawal of antiepileptic medication may precipitate status epilepticus.

The therapeutic efficacy of a dosage regimen takes several days before it can be assessed.

Use in pregnancy: Recent reports strongly suggest an association between the use of anticonvulsant drugs by women with epilepsy and an elevated incidence of birth defects in children born to these women. Reference has been made to primidone in several cases in which it was used in combination with other anticonvulsants; but its teratogenicity has not been conclusively demonstrated. The possibility exists that other factors, e.g., genetic factors or the epileptic condition, may contribute to the higher incidence of birth defects. The data also indicate that the great majority of mothers receiving anticonvulsant medication deliver normal infants.

Anticonvulsant drugs should not be discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and risk to both mother and the unborn child.

When the nature, frequency, and severity of the seizures do not pose a clear threat to the patient, good medical practice requires that the physician weigh the expected therapeutic benefit of anticonvulsant therapy against possible risk on an individual basis.

Neonatal hemorrhage, with a coagulation defect resembling vitamin K deficiency, has been described in newborns whose mothers were taking primidone and other anticonvulsants. Pregnant women under anticonvulsant therapy should receive prophylactic vitamin K₁ therapy for one month prior to, and during, delivery.

The physician should weigh all of the foregoing considerations when treating and counseling epileptic women of childbearing potential.

PRECAUTIONS: The total daily dosage should not exceed 2 Gm. Since MYSOLINE therapy generally extends over prolonged periods, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

In nursing mothers: There is evidence that in mothers treated with primidone, the drug appears in the milk in substantial quantities. Since tests for the presence of primidone in biological fluids are too complex to be carried out in the average clinical laboratory, it is suggested that the presence of undue somnolence and drowsiness in nursing newborns of MYSOLINE-treated mothers be taken as an indication that nursing should be discontinued.

ADVERSE REACTIONS: The most frequently occurring early side effects are ataxia and vertigo. These tend to disappear with continued therapy, or with reduction of initial dosage. Occasionally, the following have been reported: nausea, anorexia, vomiting, fatigue, hyperirritability, emotional disturbances, sexual impotency, diplopia, nystagmus, drowsiness, and morbilliform skin eruptions. Occasionally, persistent or severe side effects may necessitate withdrawal of the drug. Megaloblastic anemia may occur as a rare idiosyncrasy to MYSOLINE and to other anticonvulsants. The anemia responds

to folic acid, 15 mg. daily, without necessity of discontinuing medication.

DOSAGE AND ADMINISTRATION: The average adult dose is 0.75 to 1.5 Gm. per day. The initial dose is 250 mg. Increments of 250 mg. are added, usually at weekly intervals, to tolerance, or therapeutic effectiveness, up to daily doses not exceeding 2.0 Gm. A typical dosage schedule for the introduction of MYSOLINE (primidone) is as follows:

Adults and Children Over 8 Years of Age

1st Week 250 mg. daily at bedtime	2nd Week 250 mg. b.i.d.
3rd Week 250 mg. t.i.d.	4th Week 250 mg. q.i.d.

In children under 8 years of age, maintenance levels are established by a similar schedule, but at one-half the adult dosage. It is best to begin with 125 mg., with gradual weekly increases of 125 mg. a day, to a daily total usually between 500 mg. and 750 mg.

In patients already receiving other anticonvulsants: MYSOLINE should be gradually increased as dosage of the other drug(s) is maintained or gradually decreased. This regimen should be continued until satisfactory dosage level is achieved for combination, or the other medication is completely withdrawn. When therapy with this product alone is the objective, the transition should not be completed in less than two weeks.

MYSOLINE 50 mg. Tablet can be used to practical advantage when small fractional adjustments (upward or downward) may be required, as in the following circumstances:

- for initiation of combination therapy
- during "transfer" therapy
- for added protection in periods of stress or stressful situations that are likely to precipitate seizures (menstruation, allergic episodes, holidays, etc.)

HOW SUPPLIED: MYSOLINE Tablets—No. 430—Each tablet contains 250 mg. of primidone (scored), in bottles of 100 and 1,000. Also in unit dose package of 100. No. 431—Each tablet contains 50 mg. of primidone (scored), in bottles of 100 and 500. MYSOLINE Suspension—No. 3850—Each 5 cc. (teaspoonful) contains 250 mg. of primidone, in bottles of 8 fluid ounces.

References: 1. Livingston, S.: Comprehensive Management of Epilepsy in Infancy, Childhood and Adolescence. Springfield, Ill., Charles C Thomas, 1972, pp. 6, 7, 584. 2. Grossman, H.J.: Ill. Med. J. 135:260 (Mar.) 1969. 3. Scholl, M.L., in Conn, H.F.: Current Therapy 1973, Philadelphia, Saunders, 1973, pp. 675-7. 4. Metrick, S.: C.M.D. 37:49 (Jan.) 1970. 5. Forster, F.M.: Med. Clin. North Am. 47:1579 (Nov.) 1970. 6. White, P.T.: Wis. Med. J. 68:178 (Apr.) 1969. 7. Millichap, J.G.: Drug Ther. 1:15 (Oct.) 1971.



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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony,
But Both Factions Are

WASHINGTON, Aug. 26, 1920—
struggle for wom-



Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,000,000
Persons When States Adopt Cooperating Laws—He Calls
the Measure 'Cornerstone' of His Economic Program

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10,
1971—The Senate approved
today 94 to 0 and sent to

WASHINGTON, Aug. 14
The Social Security Bill, providing
a broad program of unemployment
insurance and old age pensions
and counted upon to benefit
20,000,000 persons, became law
today when it was signed by Presi-
dent Roosevelt in the presence of
those chiefly responsible for drafting
it through Congress.

Mr. Roosevelt called the bill
"the cornerstone of my economic
policy which is being built to help
the people complete their economic
rights to a better life."

TRUMAN CLOSES

UNITED NATIONS CONFERENCE
WITH PLEA TO TRANSLATE
CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain

"If we fail to use it," he declared
to the solemn final meeting of the
delegates, "we shall betray all of
those who have died in order that
we might meet here in freedom and
safety to create it."

"If we seek to use it selfishly—for
the advantage of any one nation or
any small group of nations—we
shall be equally guilty of that be-
trayal."

Fervent Interpolation

The President, speaking in the
auditorium of the War Memorial
Opera House, built in memory of
sons of the Golden Gate city who
gave their lives in the first World
War, in which he himself served,
seemed to give unconscious expres-
sion to the solemn feeling of the
occasion when, at the outset of his
speech, he interpolated the words,
"half a hope, half a prayer."

"Oh, what a great day this can
be in history!"

the Draft Ends No

WASHINGTON, Jan. 27,
1973—"With the signing of
the peace agreement in
Paris today, and after re-
ceiving a report from the

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.



THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
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America's

*

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" Effective: For controlling bronchospastic disorders. Final classification of the less than effective indication requires further investigation.

Contraindications: Because of the ephedrine, Marax is contraindicated in cardiovascular disease, hyperthyroidism, and hypertension. This drug is contraindicated in individuals who have shown hypersensitivity to the drug or its components. Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate to es-

tablish safety in early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy.

Precautions: Because of the ephedrine component this drug should be used with caution in elderly males or those with known prostatic hypertrophy.

The potentiating action of hydroxyzine, although mild, must be taken into consideration when the drug is used in conjunction with central nervous system depressants; and when other central nervous system depressants are administered concomitantly with hydroxyzine their dosage should be reduced.

Patients should be warned—because of the hydroxyzine component—of the possibility of drowsiness occurring and cautioned against driving a car or operating dangerous machinery while taking this drug.

Adverse Reactions: With large doses of ephedrine, excitation, tremulousness, insomnia, nervousness,

palpitation, tachycardia, precordial pain, cardiac rhythmias, vertigo, dryness of the nose and throat, headache, sweating, and warmth may occur. Because ephedrine is a sympathomimetic agent some patients may develop vesical sphincter spasm and result in urinary hesitation, and occasionally acute urinary retention. This should be borne in mind when administering preparations containing ephedrine to elderly males or those with known prostatic hypertrophy. The recommended dose for Marax, a side effect occasionally reported is palpitation, and this can be controlled with dosage adjustment, additional amount of concurrently administered Atarax (hydroxyzine HCl) or discontinuation of the medication. When ephedrine is given three or more times daily patients develop tolerance after several weeks of therapy. Theophylline when given on an empty stomach frequently causes gastric irritation accompanied by upper abdominal discomfort, nausea, and vomiting.



No.1 air-line[†]

Marax[®]

TABLETS: ephedrine sulfate, 25 mg; theophylline, 130 mg; and Atarax[®] (hydroxyzine HCl), 10 mg.

MARAX[®]-DF SYRUP, per 5 ml: ephedrine sulfate, 6.25 mg; theophylline, 32.50 mg; Atarax[®] (hydroxyzine HCl), 2.5 mg; and ethyl alcohol, 5% v/v.

for bronchospastic disorders*
dependable • economical • convenient

Administration of the medication after meals will help to minimize this side effect. Theophylline may cause diuresis and cardiac stimulation. The amount of Atarax (hydroxyzine HCl) present in Marax has not been associated with disturbing side effects. When used alone as a tranquilizer in the normal dosage range (25 to 50 mg three or four times a day), side effects are infrequent; even at these higher doses, no serious side effects have been reported and controlled to date. Those which do occasionally occur when Atarax (hydroxyzine HCl) is used alone are drowsiness, xerostomia and, at extremely high doses, involuntary motor activity, unsteadiness of gait, muscular weakness, all of which may be corrected by reduction of the dosage or discontinuation of the medication. With the relatively low dose of Atarax (hydroxyzine HCl) in Marax, these effects are unlikely to occur. In addition, the ataractic action of Atarax (hydroxyzine HCl) may modify the cardiac

stimulatory action of ephedrine, and concurrently, increasing the amount of Atarax (hydroxyzine HCl) may control or abolish this undesirable effect of ephedrine.

Dosage: The dosage of Marax should be adjusted according to the severity of complaints, and the patient's individual toleration.

Tablets: In general, an adult dose of 1 tablet, 2 to 4 times daily, should be sufficient. Some patients are controlled adequately with 1/2 to 1 tablet at bedtime. The time interval between doses should not be shorter than four hours. The dosage for children over 5 years of age and for adults who are sensitive to ephedrine, is one-half the usual adult dose. Clinical experience to date has been confined to ages above 5 years.

Syrup: The dose for children over 5 years of age is 1 teaspoon (5 ml), 3 to 4 times daily. Dosage for children 2 to 5 years of age is 1/2 to 1 teaspoon

(2.5–5 ml), 3 to 4 times daily. Not recommended for children under 2 years of age.

How Supplied: Marax Tablets are available as light blue, scored tablets in bottles of 100 and 500.

Marax-DF Syrup is available in pints as a colorless syrup free of all coal tar dyes, and should be dispensed in amber-colored bottles.

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[†]The most frequently prescribed bronchodilator over the last few years has been Marax—based on market research data on file at Roerig/Pfizer.

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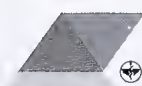
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Health and Support Services for Rape Victims on Oahu

JEANNE H. FERTEL, Ph.D., M.P.H.*, *Honolulu*

● *This paper discusses the incidence of sex abuse offenses on Oahu, their geographic and time distribution, some characteristics of the victims of such crimes, their medical and social service needs, and the resources currently available in the community for meeting those needs.*

The term "sex abuse" as it will be used here refers to the offenses of rape, sodomy, incest, molestation, and indecent exposure. These are categorized by the Hawaii Penal Code in the following manner:

Rape occurs when a man has penile-vaginal contact with a woman without her consent.

Sodomy occurs when a person has oral or anal intercourse with another without the victim's consent.

Incest refers to sexual intercourse between grandparent and grandchild, parent and offspring, brother and sister, uncle and niece, and aunt and nephew.

Molestation (also called "sexual abuse" in the Hawaii Penal Code) refers to fondling a person's body without his/her consent.

General Statistics

OCCURRENCE AND DISTRIBUTION

The data presented here were obtained from the City and County of Honolulu Police Department's Statistical Reports for 1972, 1973, 1974, and 1975, and from other documents provided by the Department's Research and Development Division. Thus, these statistics represent only those offenses which have been reported to the police. (The City and County of Honolulu is the administrative name for the Island of Oahu.)

Police statistics for sex crimes use only two categories: "rape" and "other sex offenses." The

category "other sex offenses" includes sodomy, molestation, incest, and indecent exposure. Separate statistics for each of these crimes are generally not available. However, monthly totals for Oahu were recorded from January, 1973, through August, 1974. From these data, it is possible to determine that the "other sex offenses" consisted of 7.0% sodomy, 69.9% indecent exposure, 16.9% molestation, and 8.1% "miscellaneous."

Table 1 shows the total number of reported rapes and other sex offenses on Oahu for the years 1972-1975. In 1975, there were 164 rapes reported. This is believed to be only "the tip of the iceberg," as rape is one of the most under-reported of all crimes.¹ Surveys have indicated that at least 4 times as many sexual assaults are unreported; at most, only 20% of all rapes are reported.² This implies that there were approximately 820 rapes on Oahu in 1975. This could be a conservative estimate, as some authorities estimate that only 10% of all rapes are reported.

Fig. 1 describes the hours of the day when reported rapes and other offenses occur. Reported rapes have occurred primarily in the evening and at night, with 69.2% taking place between 7:00 P.M. and 5:00 A.M. On the other hand, other sex offenses which are reported seem to occur mainly during the day, with 69.4% occurring between 7:00 A.M. and 7:00 P.M. This distribution is clearly distorted by the overwhelming predominance of indecent exposure cases (approximately 70%), which are probably more likely to occur during the day (or to be noticed during the day). Since separate figures are not available in the geographical and time distributions of the individual crimes included under "other sex offenses," no further statistical analysis of this category will be made and it will be assumed that the statistical patterns of sodomy and molestation follow those of rape.

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Accepted for publication July, 1977.

TABLE 1.—Occurrence of Reported Rapes and Other Sex Offenses on Oahu

YEAR	REPORTED RAPES	REPORTED OTHER SEX OFFENSES
1972	145	298
1973	152	286
1974	194	324
1975	164	363

FIG. 1—Occurrence of reported rapes and other sex offenses by time of day, Oahu, Hawaii, 1974-75.

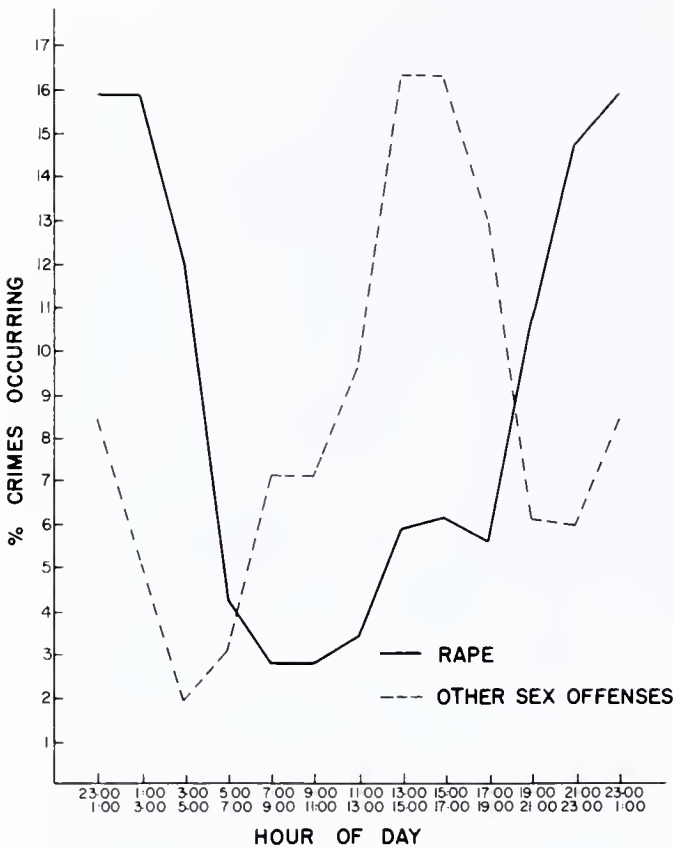
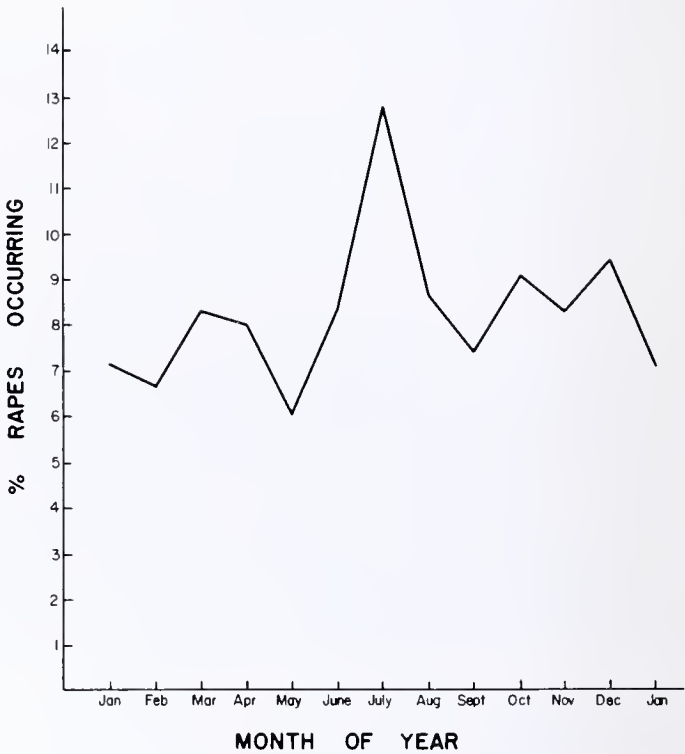


Table 2 describes the distribution of reported rapes throughout the week. A higher proportion of rapes occur on Monday and Saturday (34.1%) than on other days. However, there is no day when rape is particularly unlikely to occur.

Fig. 2 shows the variation in reported rapes throughout the year. There is an unusually high frequency of rape in July. (On the U.S. mainland, August is the month of highest risk). Otherwise, reported rapes are evenly distributed throughout the year.

An approximate density map showing the geography of rape in rural Oahu is given in Fig. 3. Dots are randomly distributed within each police beat, with each dot representing one rape reported during the period, 1972-75. The areas of greatest risk on Oahu, excluding Metropolitan

FIG. 2—Occurrence of reported rapes by month of year, Oahu, Hawaii, 1974-75.



Honolulu, are those surrounding Kailua and Kaneohe, Sunset Beach, Waipahu, and the Waianae Coast. An exception on the Waianae Coast is Police Beat 322 where no rapes were reported during this period. During the period 1972-75, 58.8% of all reported rapes occurred in Metropolitan Honolulu (District I). As it is generally assumed that from 75% to 90% of all rapes are not reported, and there are no estimates as to the percentage of unreported sodomy and molestation incidents, there is no way of knowing whether the characteristics of sex abuse offenses and victims described from the police statistics are typical of the sex abuse population as a whole.

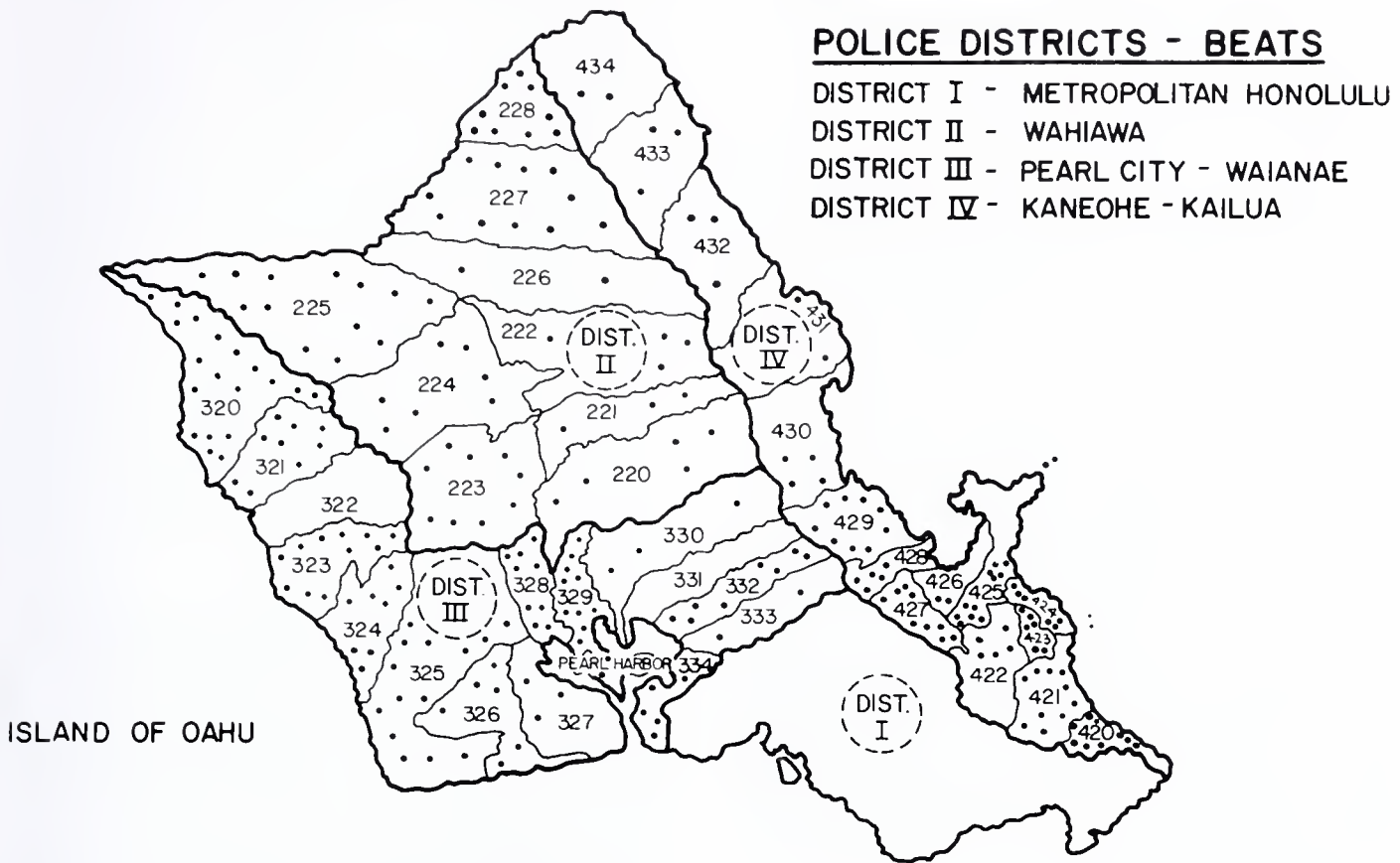
CHARACTERISTICS OF VICTIMS

The following data on the age and sex distribution of sex abuse victims were taken from monthly reports kept by the Honolulu Police Department's Research and Development Divi-

TABLE 2.—Percentage of Reported Rapes by Day of Week, Oahu, 1974-75

SUN	MON	TUE	WED	THU	FRI	SAT
13.7	18.2	12.0	13.4	12.8	14.0	16.0

FIG. 3—Distribution of 270 rapes reported by police beats on rural Oahu, 1972-75. Each dot represents one rape. There were 385 rapes reported in District I, or 59% of the total of 655 for Oahu, during the same period.

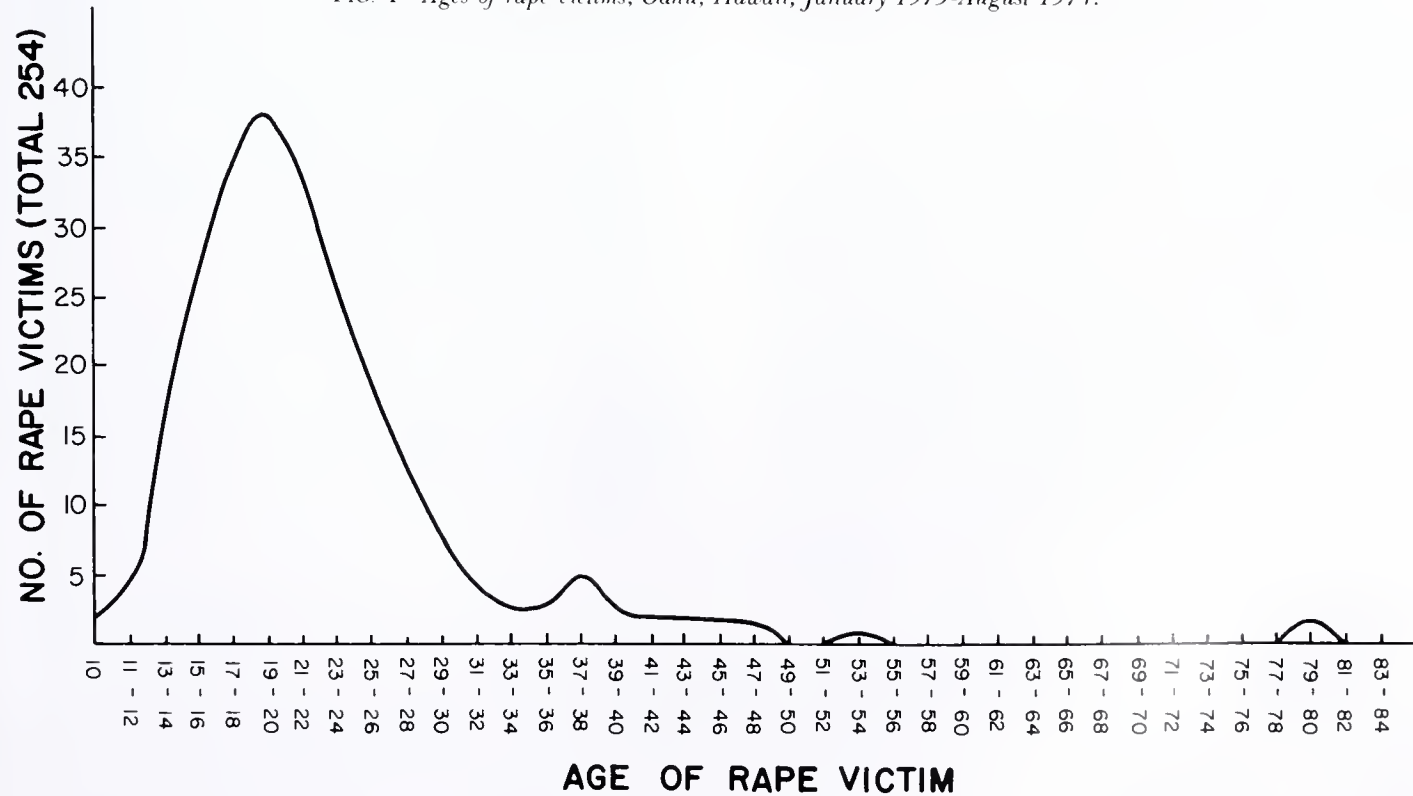


sion from January, 1973, to August, 1974. More recent data are not available.

The age distribution of victims of reported rape on Oahu is described in Fig. 4. Seventy-one percent of the victims were between the ages of 15 and 26. The youngest reported victim during this period was 10 years of age and the oldest was 80 years.

The definition of rape in the Hawaii Penal Code prescribes that the victims of this crime must be women, although victims of sodomy and molestation can also be men. Between January, 1973, and August, 1974, approximately $\frac{1}{3}$ of the sodomy victims and $\frac{1}{12}$ of the victims of molestation were male. Age distributions for these offenses are not available.

FIG. 4—Ages of rape victims, Oahu, Hawaii, January 1973-August 1974.



Administrative Procedures

A rape victim who chooses to interact with the health care or criminal justice system will normally go through some or all of the following steps:

1. HOSPITAL

Most private physicians on Oahu do not treat rape victims. The major facility available for the treatment of such victims is the Sex Abuse Treatment Center (SATC) at Kapiolani-Children's Hospital, which opened in October, 1976. Indeed, this is the only facility in the entire State of Hawaii which has specialized services aimed at meeting the needs of victims of sex abuse.

A woman who has been raped may call either the SATC, the police, the Suicide and Crisis Center, or the voluntary organization Women Against Rape. If she calls the Police or SATC, they will send someone to pick her up wherever she is. She will usually be taken to the hospital first.

At SATC she is met by a "crisis worker" who has been called in. She is then examined, given various medical and legal tests, and treatment as indicated. The crisis worker is expected to see that the victim has a way to get home, and to find out what kind of support network she has among her friends and family.

2. POLICE (RAPE SQUAD)

Although the law requires that the crime must be reported to the police, in practice the victim does not have to do this herself. If she does not wish to report to the police in person, she can report via a "third-party" reporting form which is filled out at the SATC and sent to the police station.

If she does wish to report to the police, the hospital will notify the police Rape Squad. They will come to the hospital and either question the victim there or take her back to the station for questioning.

3. PROSECUTOR'S OFFICE

The Rape Squad will conduct an investigation. If they arrest a suspect and think they have a case, the victim will be sent to the prosecutor's office. A counsellor from SATC takes over from the crisis worker and is available to accompany the rape victim through the legal system. At the prosecutor's office she will be questioned thoroughly so that the prosecutors can determine whether there is enough evidence to make a successful prosecution likely, and whether she will make a good witness.

4. COURT

An accused rapist has the option of choosing to be tried by a jury or a judge. He usually elects a jury trial. Before the trial begins, during the *voir dire* procedure, the prosecutor and defense attorneys have a chance to question the prospective jurors and each of them may arbitrarily remove any 3 jurors for any reason. At a trial attended by the author, the defense attorney came from the Public Defender's Office. Among the questions he asked the prospective jurors were the following:

- Have any of you seen any television programs about rape recently?
- Have any of you read any articles implying that rape laws are unfair or that rape victims are treated unfairly?
- Do any of you read any women's consciousness periodicals such as *Ms. Magazine*?
- Are any of you members of any national women's organizations such as the National Organization for Women?

In response to the last question, one woman raised her hand and said she was a member of the American Association of University Women (AAUW). She was removed from the jury.

It would seem from these questions that the ideal juror is someone who does not have much political awareness and is not too well-informed. Indeed the second question would disqualify anyone who is even aware that rape laws are controversial. Since most newspapers and magazines occasionally publish articles on the subject, anyone who regularly reads any of these periodicals would be ineligible to sit on a rape jury.

It is not surprising, under the circumstances, that the trial is often dominated by appeals to emotion. The prosecutor usually tries to make the jury identify with the victim and the defense attorney tries to make them identify with the accused. Unlike many states, Hawaii has a law against "character assassination," which prohibits the defense attorney from questioning the victim about her past sexual history, unless this testimony has first been screened in closed court and approved by the judge.

Very few rape trials result in convictions. Of 21 adult men who were prosecuted for rape on Oahu in 1975, only 3 were convicted. Table 3 shows the attrition from the number of rapes to the number of convictions for the entire United States for 1973.

TABLE 3.—*Rapes and Rape Convictions, U.S.A., 1973*

ESTIMATED TOTAL RAPES	RAPES REPORTED	ARRESTS	PROSECUTIONS	CONVICTIONS
255,000	51,000	26,000	19,750	10,470

Data from FBI Uniform Crime Reports¹

Hospital Functions

1. MEDICAL NEEDS OF VICTIMS

No detailed information is available on the nature or severity of any injuries suffered by rape victims on Oahu, in addition to the rape. Therefore the following data are taken from studies done in Washington, D.C. and Boston.

Between September, 1965, and June, 1969, 2,160 rape victims underwent medical examinations by direction of the Metropolitan (D. C.) Police.² Of these, 24 (or 1.1%) required hospitalization. Seven were admitted to the hospital because of vaginal or vaginoperineal tears, and 17 for other injuries: fractures, severe multiple lacerations and abrasions, head injuries, stab wounds, and one torn digital nerve. Another 58 women and girls (or 2.6% of the total) required major treatment in the emergency room. Of these, 11 were children with vaginoperineal tears. In addition "many hundreds" required treatment of minor injuries. During this period, 84 male victims of sexual abuse were also brought for medical examinations by the police. No information is given on the nature or extent of their injuries.

At Boston City Hospital,³ initial general physical examinations of 80 rape victims showed 147 signs of trauma or lacerations of the head, face, throat, chest, abdomen, back, arms, and legs. Of these 80 women, 12 required medical, surgical, or orthopedic consultation in addition to X-ray services to confirm a diagnosis secondary to the rape diagnosis. Further gynecological examinations identified an additional 57 bruises and lacerations of the genital organs, perineum, and anus. However, the report does not say how many of the victims had signs of trauma or lacerations.

In addition to victims requiring treatment of the kinds of injuries described above, those with minor wounds may require tetanus toxoid. All victims also need to have pelvic examinations, diagnostic tests, and treatment which is specifically for the rape. Women who are menarchal and not using oral contraceptives or wearing an IUD may wish to be given ethinyl estradiol or stilbestrol for pregnancy prophylaxis. All victims of rape or sodomy need to be given either an antibiotic for V.D. prophylaxis or tested for V.D.

Although tests for pregnancy and venereal disease are usually performed immediately, these will only indicate whether the victim had V.D. or was pregnant at the time of the rape. Follow-up tests must be made later to see if she contracted either of these conditions as a result of being raped.

2. LEGAL REQUIREMENTS FOR PROSECUTOR

In addition to the diagnostic tests and medical treatment described above, the following procedures for collecting legally admissible evidence from the victim need to be performed:

1. Acid Phosphatase
2. Collect further specimens to document the identity of the offender (for testing for ABO antigens by the Honolulu Police Department).*
3. Ultraviolet Wood's Lamp used to fluoresce seminal fluid on body or clothing.
4. Original clothing should be saved for police.
5. Photographs taken of injuries.
6. Wet Mount
 - a. vagina
 - b. other
7. Urine Specimen

Most of these are tests for the presence of semen and sperm; their results will constitute evidence of rape which can be presented in court, should the victim decide to prosecute. It is therefore important that she not bathe or douche before being seen by a doctor.

In order for the specimens and test results to be eligible for introduction as evidence, what is called the "chain of custody" must be maintained. This means that the evidence must be in someone's custody at all times, and there must be a record of who had custody and of every time the custody was transferred, so that it can be ensured that the evidence presented in court is the same as that taken from the victim. In order to establish and maintain the chain of custody, the following procedures are used:

The equipment used for collecting the specimens from the victim is kept in a box in a part of the laboratory which is locked. The nurse signs for the box when collecting it for the examining room. The doctor assembles the necessary equipment, collects the specimens, and puts them in the box. The nurse then takes the box to the laboratory. The person receiving it at the laboratory signs a form for receipt of the box containing specimens from patient X. The tests are then made and the forms describing the results completed for the police.

The victim signs separate consent forms for photographing of her injuries, collecting of specimens for evidence, and release of evidence to the police.

The physician, in addition to filling out the laboratory requisition forms, signs a form describing the signs of trauma and certifying that the evidence in the box was collected from this patient.

The laboratory chemist fills out the forms describing the evidence and test results for the police.

3. EMOTIONAL NEEDS OF VICTIMS

Rape victims have been observed to go through several stages in their emotional reaction to having been sexually assaulted.^{4,5}

*These tests are not currently being performed by the Police Department.

The initial reaction is usually a state of shock or extreme anxiety, known as the acute phase. The victim may become very agitated or she may appear supernaturally calm. Physical symptoms of this stage may include sleep disturbance, startle reactions, tension headaches, loss of appetite, and stomach upset. Victims often express feelings of overwhelming fear. Life style is disrupted.

At this point the victim's need is for crisis counselling. Such counselling typically focuses on the immediate crisis without giving much consideration to the victim's previous problems. It can be provided by nurses or social workers at the hospital where she goes for her initial treatment.

The acute phase ends when the victim resolves her general anxiety and returns to her normal life style. This may be a matter of days or weeks.

The second phase is one in which the victim makes what outwardly appears to be a satisfactory adjustment. She is no longer acutely upset and she tells people that things are back to normal and that she's all right now. She may be conscious of the incident through dreams or daydreams, but is able to consider it insignificant. The problem however is usually only suppressed. She has not recognized and dealt with her anger against her assailant or the fact that her world is less secure now.

At this time, the victim has little or no desire for outside help and may indeed resent it. The emotional repression or denial of rape can last for years. Indeed, with some women, this phase can last for the rest of their lives.

The normal progression to the third phase begins when the victim becomes depressed and starts to spend a great deal of time painfully reliving the incident. Or some other incident may occur which brings her repressed feelings of anger to the surface. Some women may arrive at this point without going through the suppression stage at all.

Whatever way she gets there, the third phase occurs when the victim confronts her feelings of rage and vulnerability and reorganizes her life. Many victims move to a different neighborhood, change to an unlisted phone number, seek out family members they have not previously been close to, or change their life style in some other way. She may wish to re-examine and adjust her relationships and her feelings about herself in order to re-establish her security.

A follow-up study of 146 adult and pediatric rape victims in the greater Boston area was undertaken in order to determine their long-run counselling needs.⁶ The women received regular telephone calls from the counsellors over periods ranging from several months to several years after the incident. During these telephone counselling sessions, 42% of the victims expressed the need for ventilation, 24% wanted help in clarifying their thoughts and feelings, and 8% asked for advice on how to deal with a specific social, physi-

cal, or psychological problem related to the rape. Though having no specific counselling requests, 32% said that they were glad to know the counsellor was available. Only 16% of the women in the study could not be followed up or felt no need for any contact with a counsellor.

Professional Attitudes

The generally hostile attitude of health professionals toward dealing with victims of sexual assault is well known.^{7,8,9} Many, if not most, hospitals are reluctant to treat rape victims and some refuse to do so outright. The following reasons have been given by medical personnel for this reluctance:

1. "Too much trouble": Many physicians complain that the tests, the forms, and particularly the "locked box" and the procedures associated with it are burdensome. Others, however, have insisted to the author that those parts of the procedure which are performed by the M.D.—collecting the specimens and filling out the laboratory requisition forms—are no more complicated than routine tests which are ordinarily performed on emergency-room patients. The forms for the police are not filled out by the physician but by the laboratory personnel.

2. Testifying in court: Doctors often say that they are unwilling to get involved with treating rape victims because it might require them to appear in court, thus taking time away from their practices. The State of Hawaii compensates its witnesses only at the rate of \$4.50 an hour and 10¢ per mile travelled. The Sex Abuse Treatment Center has agreed to pay its attending physician \$50 an hour for his appearances in court, in order to make the burden less onerous.

In practice, however, the physician is rarely called upon to testify in court. In its 6 months of operation, the SATC has never had its physician summoned. Usually the prosecutor is willing to rely on the documentary report for the test results in order to establish that rape took place.

3. Sexual politics or "It can't happen to me.": Most people like to think that violence is something which happens only to others. When reading of a violent crime, they like to imagine that the victim did something stupid and that they would have been smarter in the same situation. This enables them to avoid confronting their own vulnerability. When the crime is rape, where a stigma has traditionally been attached to the victim, it is particularly tempting to imagine that she did something stupid or careless and so invited the attack. When the attending physician is a man it is particularly easy for him to avoid feeling vulnerable.

Women too, whether as medical attendants in the emergency room or as jurors, have been known to feel this self-protective hostility toward victims of rape. Traditionally, defense attorneys have wanted to have women on the jury because of their belief that women are "hard" on other

women.⁷ They expect that the women listening to the victim's story will say, "She did something foolish that I wouldn't have done. Therefore it couldn't happen to me." Before opening, the Sex Abuse Treatment Center conducted sensitivity training sessions for its nurses so that they could become aware of and discuss their feelings about rape and rape victims. Instilling awareness should also be part of the training of physicians along with the instruction in the medical procedures.

Conclusion

It should be kept in mind that the various aspects of treating rape victims discussed in this paper are simply palliatives. Ideally, rape is something which should not be happening at all. Dealing adequately with the problem of rape requires more than the kind of band-aids which

have been described here. It will require confronting and changing socially accepted norms of male aggression and female passivity, of which rape is just an extreme manifestation.

Acknowledgements

I am grateful to Nathan Matsuoka and Gloria Yoshikami of the Research and Development Division of the Honolulu Police Department for the statistics used in preparing section II; to Paula Chun and Gwen Costello for information regarding the operation of the Sex Abuse Treatment Center at Kapiolani-Children's Hospital; and to Professor R. Warwick Armstrong of the Department of Community Health Development, University of Hawaii School of Public Health for commenting on the draft of this paper.

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On the changing lab scene . . .

Amylase-Creatinine Clearance Ratio
in the Diagnosis of Acute Pancreatitis

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Serum amylase was the time-honored test for the diagnosis of acute pancreatitis for many years. Later, serum lipase was added for another important parameter. An elevation in the latter, however, can only be expected 2-3 days after the initial onset of the disease, and even then, in most

laboratories, it can be a tedious test to perform. In 1957 Saxon et al¹ reported on the value of doing urine amylase as a test for pancreatitis. It was an important addition to our diagnostic armamentarium. However, its performance is complicated by the necessity for accurate 24-hour or other timed urinary collections. Gambill and Mason² maintain that 2-hour urine collections are equally reliable and less tedious than 24-hour collections. Results are reported as units of urine amylase excreted per hour. It has become apparent, however, that renal clearance of amylase in cases of pancreatitis is extremely variable in a 24-hour period, ranging from increased to decreased levels of clearance; therefore, false-negative values do occur.

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In 1969 Levitt et al³ suggested that the best test would be a determination of the ratio of the renal clearance of amylase to the renal clearance of creatinine. They proposed measuring the ratio as a percentage, thus eliminating the need for a timed urine specimen. A number of subsequent articles have confirmed their results.^{4,5,6,7,8} The ratio is derived in the following manner:

$$\begin{aligned}
 &C = \text{Clearance} & V = \text{Volume} \\
 &am = \text{Amylase} & T = \text{Time of Collection} \\
 &cr = \text{Creatinine} & U = \text{Urine} \\
 &S = \text{Serum}
 \end{aligned}$$

$$\begin{aligned}
 \text{Ratio} &= \frac{C_{am}}{C_{cr}} \times 100 \\
 &= \frac{\frac{U_{am} \times V_{urine} \times T}{S_{am}}}{\frac{U_{cr} \times V_{urine} \times T}{S_{cr}}} \times 100 \\
 &= \frac{U_{am} \times S_{cr}}{S_{am} \times U_{cr}} \times 100
 \end{aligned}$$

In order to obtain the ratio, only the concentrations of amylase and creatinine in simultaneously collected "spot" samples of serum and urine are necessary. For convenience, the C_{am}/C_{cr} ratio is expressed as a percentage by multiplying by 100.

The causes of hyperamylasemia and hyperamylasuria are legion, with nonpancreatic disorders outnumbering by far pancreatic disease.⁹ Some studies⁴ maintain that the C_{am}/C_{cr} ratio is fairly specific for pancreatitis, while others report that the ratio is elevated in patients with diseases such as diabetic keto-acidosis, burns and severe renal insufficiency.⁵ Decreased renal tubular reabsorption of filtered amylase has been implicated¹⁰ as the cause of the increased clearance ratio. The determination of serum lipase activity should be determined when necessary. For practical purposes, the normal range for the C_{am}/C_{cr} ratio can be considered to be 1-5%.

During the first few days of acute pancreatitis, the average value is about $9.0 \pm 1.0\%$. A normal C_{am}/C_{cr} ratio early in the course of pancreatitis is uncommon. However, in Warshaw and Fuller's⁴ study, 3 out of 42 patients with pancreatitis had a value below 5.3, and 2 subjects (one control and one with a disease other than pancreatitis)

had a value above 5.0%. The usual sequence of regression of parameters in pancreatitis is first normalization of serum amylase, next the urinary amylase and finally the C_{am}/C_{cr} ratio.

The measurement of the simple ratio of urinary amylase to urinary creatinine—reported as units of amylase per mg of creatinine—can be useful in differentiating pancreatitis from other abdominal disease.¹¹

We are presently investigating the correlation of the two ratios in suspected cases of pancreatitis. In normal controls the two values are in excellent agreement. The normal range for the ratio of urinary amylase to urinary creatinine (U_{am}/U_{cr}) is 0.6 to 5.2 with a mean of 2.9 ± 2.3 (2 SD).

In Summary:

1. Hyperamylasemia and hyperamylasuria are not specific indices of the presence of pancreatic disease.
2. Serum and urinary amylase levels can be spuriously normal with hypertriglyceridemia and pancreatitis, because of the presence of a non-lipid serum inhibitor which is filtered into the urine.¹² The suppressed amylase activity can be unmasked by dilution with saline.¹³
3. Development of the C_{am}/C_{cr} ratio may provide a practical diagnostic tool for separating clinical significant hyperamylasemia due to pancreatitis from that caused by other factors (a normal ratio in intestinal infarction and duodenal perforation with hyperamylasemia).
4. Using the C_{am}/C_{cr} ratio with the range of 1-5%, one can distinguish patients with acute pancreatitis and macroamylasemia from patients without pancreatic disease. In diabetic keto-acidosis the ratio is elevated to levels identical to acute pancreatitis. Serum lipase measurements may distinguish between diabetic keto-acidosis and acute pancreatitis.
5. Simultaneous evaluation of the serum amylase, the urinary amylase and calculation of the C_{am}/C_{cr} ratio is superior to the diagnostic significance of amylase determinations alone.
6. Sequential determination of these three parameters affords more precise data concerning the clinical course of acute pancreatic inflammation than the routine amylase levels in the blood or urine alone.

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HAMPAC-AMPAC Workshop-Seminar—January 14th HAMPAC and AMPAC will sponsor a political workshop for all physicians and their spouses on Saturday, January 14th at the Ala Moana Hotel. The program, which includes luncheon, begins at 9 A.M. and will feature Dr. Rex Kenyon, M.D., Chairman of AMPAC, and U.S. Senator Spark Matsunaga, as well as members of Hawaii's own state legislature. This session is planned as an educational workshop for physicians and their spouses covering the importance of the legislative process, political action, and candidate support in the present medical legislative climate and also to trace the history and development of AMPAC and HAMPAC since the early 60's.

At the conclusion of the day's program there will be an informal no-host cocktail party for attendees and guests. Registration fee for the workshop, including lunch, will be five dollars for each attendee. 1978 sustaining AMPAC/HAMPAC members will have their registration fee waived. A sustaining member is one who makes a voluntary \$100 membership contribution to AMPAC/HAMPAC.

It is imperative that organized medicine be supportive of those legislators who support the delivery of medical care under a free enterprise system. Arrange your Saturday January 14th schedule now to insure that you and your spouse can attend this worthwhile function relating to physician involvement in the political process.

1978 is another important election year for Hawaii's physicians. The workshop will provide an excellent opportunity for neighbor island as well as Honolulu physicians and spouses to learn how they can exert strong political influence during the 1978 state legislative session as well as at the November elections.

HAMPAC will mail advance registration and program information to all physicians during December.

AUXILIARY PROVIDES FIRST HAMPAC/AMPAC SUSTAINING MEMBER FOR 1978: Elizabeth Bell, a member of HMA Auxiliary's legislative committee, became Hawaii's first 1978 HAMPAC/AMPAC sustaining member at HMA's November Annual Meeting. In addition to her membership on the auxiliary's legislative committee, Mrs. Bell will also be serving in her second year as a member of HAMPAC's Board. Other auxiliary members who are serving on the 1978 HAMPAC Board are Naomi Yamashiro, Alice Tucker and Barbara Mills.

POLITICS HAWAIIAN STYLE Alice Tucker and Elizabeth Bell, both members of the HMA Auxiliary Legislative Committee as well as Directors of the HAMPAC Board, were in attendance at a special workshop of legislators, labor and business representatives to learn how organized medicine could play an influential role in the legislative process. "Participate, and when you do, be effective" was the message brought back by our auxiliary representatives who were attending the Hawaii Chamber of Commerce "Politics Hawaiian Style" workshop at the Hilton Hawaiian Village on November 18th.



How a law can be perverted by bureaucrats

Organized medicine is striving to have Public Law 93-641 repealed. Why?

It is the "health planning" law. What can be wrong with planning for a coordinated system of health care that will close all gaps and that will try to assure all citizens of the availability and affordability of quality medical care—to prevent ill-health, as well as to treat disease, injury and disability?

Nothing! Except . . .

Proceedings of
The House of Delegates



121st Annual Meeting
October 31 - November 4, 1977

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 J. Mark Sowers (Maui)

Medical Education

Edgar Ho, Chairman & Commissioner
 Vincent Aoki
 Nadine Bruce
 Ann B. Catts
 Benjamin Chang
 Pill W. Hong
 Ivar Larsen
 Winfred Y. Lee
 James Lumeng
 Bal Raj Mehta
 James Orbison
 Mitsuaki Suzuki
 Patrick Walsh
 John R. Watson
 Thomas Whelan
 Manas Ghosh (Hawaii)
 Sakae Uehara (Maui)
 (Kauai)

Nominating

Andrew I. Morgan, Chairman
 Ralph Beddow
 William W. L. Dang
 Winfred Y. Lee
 R. Varian Sloan
 Kenneth Hughes (Hawaii)
 William E. Iaconetti (Maui)
 Thatcher Magoun (Kauai)

Peer Review

Chew Mung Lum, Chairman
 Ann B. Catts, Commissioner
 Murray Berger
 Frank E. Ceccarelli
 William W. L. Dang
 Takakazu Fukumura
 Victor Hay-Roe
 Malcolm Ing
 Bal Raj Mehta
 James Penoff
 Ernest L. Bade (Hawaii)

Pharmacy

Vincent S. Aoki, Chairman
 George Goto, Commissioner
 Thomas Cashman
 Amelia Jacang
 Bert Lum
 James Lumeng
 Daniel Palmer
 Yonemichi Miyashiro (Kauai)

Professional Liability

Bernard W. D. Fong, Chairman
 Ann B. Catts, Commissioner
 Walter W. Y. Chang
 Clifford Chock

John W. Edwards Jr.
 Raymond H. Fujikami
 George Goto
 David Kimura
 Gail G. L. Li
 John Lowrey
 Chew Mung Lum
 Gabriel Ma
 Mor McCarthy
 Robert Thune
 John Watson
 George Bracher (Hawaii)
 Peter Kim (Kauai)
 John N. Withers (Maui)

Public Affairs

Virgil Jobe, Chairman
 Rowlin Lichter, Commissioner
 John Corboy
 Charlotte M. Florine
 George Monlux Jr.
 James Penoff
 Margaret Rose
 Doris Jasinski
 George Schnack
 Theodore Tseu
 William A. MacDonald (Maui)

Public Safety

Truett Bennett, Chairman
 Roy Kuboyama, Commissioner
 R. C. Dusendschon
 Sigdian Lim
 John Spangler
 Ramon Sy
 James Fleming (Maui)

Publications

William F. Moore Jr., Chairman
 Douglas B. Bell II, Commissioner
 Harry L. Arnold Jr.
 Doris R. Jasinski
 James Lumeng
 J. I. Frederick Reppun
 John R. Watson
 Henry Yokoyama

School Health

Fernando Atienza, Chairman
 Roy Kuboyama, Commissioner
 Donald Char
 Michael Hase
 Amelia Jacang
 Noni Brar Koch
 John Peyton
 George Schnack
 Betty Soo
 Stephen Tenby
 Kirsten Vennesland
 Ann Barbara Ho Yee
 Franklin Young
 Denis Fu (Maui)
 Edward Underwood (Maui)
 Arch Wigle (Hawaii)

Scientific

Herbert Uemura, Chairman
 Vincent Aoki
 Douglas B. Bell II, Commissioner
 Nadine Bruce
 Benjamin Chang
 R. Varian Sloan
 Clifford Straehley
 Patrick Walsh
 John Watson

Self-Insurance, Ad Hoc

John Edwards Jr., Chairman

Albert C. K. Chun-Hoon
 William W. L. Dang
 George Ewing
 Bernard Fong
 Elmer Johnson
 Gail G. L. Li
 Gabriel Ma
 Maurice W. Nicholson
 L. Q. Pang
 Alan Pavel
 Alexander Roth
 Sakae Uehara

Sports Medicine

Edward Kagihara, Chairman
 Roy Kuboyama, Commissioner
 Edward Beckman
 Sharon Bintliff
 Robert DiMauro
 Virgil Jobe
 Noni Brar Koch
 Robert Lindberg
 Robert May
 Ichiro Nadamoto
 Robert Nemechek
 Michael Okilhiro
 R. Reginald Patterson
 Benjamin Tom
 Patrick Walsh
 Franklin Young
 P. M. Cockett (Kauai)

Substance Abuse

James Lumeng, Chairman
 Roy Kuboyama, Commissioner
 Judith Begley
 Donald Char
 Edwin Curphey
 Patrick Donley
 Virgil Jobe
 Audrey Mertz
 Neal Winn
 James Mayer (Hawaii)

TV-Radio

Henry Yokoyama, Chairman
 Rowlin Lichter, Commissioner
 Samuel Allison
 John Corboy
 Virgil Jobe Jr.
 John Keenan
 Sigdian Lim
 George W. Monlux Jr.
 William A. Myers
 Ronald Pion
 Marco Rizzo
 E. Lee Simmons
 Paul Berry (Punahou School)
 Gene Kois (Videololo)
 Helen Percy (Maui)
 Russell T. Stodd (Maui)

Worker's Compensation

Bernard M. Scherman, Chairman
 William F. Moore, Commissioner
 Francis T. C. Au
 Patrick Donley
 Raymond Dusendschon
 William Iaconetti
 David Kimura
 Ben Leung
 Herbert K. N. Luke
 Maurice W. Nicholson
 L. Q. Pang
 R. Reginald Patterson
 James S. Phillips
 Robert L. Simmons
 Edward B. Underwood (Maui)

PROCEEDINGS OF THE HOUSE OF DELEGATES

121st Annual Meeting of the Hawaii Medical Association

The first session of the House of Delegates meeting was called to order by President Calvin C.J. Sia on Wednesday, November 2, 1977, at 1:30 p.m. in the Molokai Room of the Sheraton Waikiki Hotel. Dr. Douglas B. Bell II, Secretary, called the roll. Present were Drs. Calvin C.J. Sia, Marion Hanlon, William W.L. Dang, Douglas B. Bell II, Grover H. Batten, Ann B. Catts, Gary Salenger for William Kepler, Richard Lundborg, Thatcher Magoun, Albert Chun-Hoon, George Goto, Leonard Howard, J.I.F. Reppun, John Edwards, Calvin C.M. Kam, Sakae Uehara, Peter Kim, Herbert Y.H. Chinn, William E. Iaconetti, J. Alfred Burden, Winfred Y. Lee, George H. Mills, and O.D. Pinkerton. Delegates present from county societies included: Honolulu-Drs. Nadine Bruce, Thomas Cahill, Walter W.Y. Chang, Richard Fardal, Fred I. Gilbert, Jr., Charles Judd, Edward Kagihara, Roy Kuboyama, Felix Lafferty, Wayne McKinny, Victor Mori, Michael Okilhiro, John Pearson, Shigemi Sugiki, Margaret Rose, Patrick J. Walsh, Neal Winn, Eugene G.C. Wong; Maui-Andrew Don, Denis Fu, Jose Romero; Hawaii-Ernest Bade, Ruben Casile, R.P. Wipperman. There were no delegates from Kauai County.

Dr. John H. Budd, President of the American Medical Association, was invited to address the House of Delegates. Dr. Budd referred to various activities of the AMA and noted that more than fifty percent of the AMA budget is spent for education. He stressed that it is only through the AMA that all physicians may stand as one.

Dr. William Dang was appointed to serve as parliamentarian for the meeting. Drs. Denis Fu and Felix Lafferty were appointed sergeants at arms.

The minutes of the 120th Annual Meeting as published in the December 1976 issue of the HAWAII MEDICAL JOURNAL were approved as published.

The reports of the President, Secretary, Treasurer and component societies were included in the delegates handbook and referred as indicated. The resolutions were also assigned to reference committees.

Reference Committees were appointed as follows: Public Health - Thatcher Magoun (Chairman), Roy Kuboyama, Ernest Bade, Neal Winn and Charles Judd; Miscellaneous Business - Thomas C. Cahill (Chairman), Richard Fardal, George Goto, Richard Lundborg, and Leonard Howard; Finance and Peer Review - Ann B. Catts (Chairman), J.I.F. Reppun, John Edwards, Peter Kim, and Eugene Wong.

The reference committees were in session November 2 beginning at 2:30 p.m.

The second session of the House of Delegates was called to order on Thursday, November 3, 1977, at 1:30 p.m. In addition to the delegates listed, present on Wednesday were Drs. Andrew Morgan and Victor Mori from Honolulu County.

Reference Committee On Public Health

Honolulu County Medical Society

ACTION: Filed

This has been a year of re-assessment of county society activities and goals while continuing to provide the usual services and functions through committees. An Ad Hoc Committee on Planning was composed of a broad representation of the membership as well as former members. After much study this committee organized and conducted an open forum for members, non-members, and spouses to identify priorities and goals for the county society. The forum was well-attended and stimulated some very worthwhile discussions, the results of which are being reviewed by the Ad Hoc Committee on Planning for eventual recommendations to the Board of Governors.

Attendance at membership meetings continues to be a problem and a variety of programs was arranged by the program committee. In February, there was "Mixing Medicine with Politics"; April, "When to Retire—A Physician Dilemma"; June, "Pain—A Personal Experience"; and October, "Alternative Methods of Obtaining Professional Liability Protection." The last two programs had the best attendance; the June meeting was accredited for CME-Category I credit.

Another Ad Hoc Committee originally appointed for diabetic screening was enlarged in membership and scope to provide advice to all community medical screening clinics and to begin an evaluation and compilation of such services on Oahu.

Our contractual financial arrangements with HMA have had about one year of trial. Review of these financial arrangements should suggest any changes necessary before the HCMS and the HMA budgets are finalized.

We continue to be blessed by a dedicated and efficient staff led by Mr. Jon Won. Restructuring of the staff organization by Mr. John Won has resulted in a greater sharing of responsibility and greater latitude in decision-making. Those members who are active in committee functions are well-aware of the staff's expertise and competence, but we often neglect to let them know of our appreciation.

The year ahead may bear fruit from some of the efforts of this past year, particularly through the work of the Ad Hoc Planning Committee. Everyone needs to become better informed and more involved in County society business in order to adopt changes which reflect the majority opinion of the physicians.

ANN B. CATTS, M.D.

Maui County Medical Society

ACTION: Filed

The Maui County Medical Society met regularly on the 3rd Tuesday of each month to consider matters of concern to the local medical community. The recurring theme seemed to be politics and medicine. Our programs included a visit by Dr. Calvin Sia, Dr. Leonard Howard, Senator Pat Saiki, as well as representatives from the EMS program, Maui Vice Squad, and HAPI.

The society has been active in community affairs. After much negotiating and a lot of effort we have succeeded in bringing TelMed to the island. We have regularly placed public service announcements on the radio which are called "Health Tips." We have a regular column in the newspaper called *Materia Medica* which has carried articles of general medical interest written by Maui physicians.

We now have 65 active members and their attendance at meetings has been excellent. Next year we look forward to continued close association with the state association as well as active involvement in political affairs.

WILLIAM KEPLER, M.D.

Hawaii County Medical Society

ACTION: Approved as amended.

The HCMS experienced a difficult year in 1977. In spite of some positive aspects and accomplishments including the introduction of a revised constitution, an ongoing program of educational speakers at the monthly meetings, recommendations forwarded to the HMA to upgrade VA fees and after our constitution regarding peer review, initiation of a historical review of the "old HCMS" by Drs. Wipperman and Mizuire, the general tenor of the year was one of anguish and frustration principally generated by complex and difficult

peer review problems and unwieldy and ineffective mechanisms of solution.

These ineffective mechanisms are related to several facts: First, proper investigation requires considerable experience, time, legal advice, and willingness of society members to pursue a complaint. A society that is spread out over a large land mass, that has few members, that has minimal financial resources for legal and investigative fees cannot do a proper peer review job; Secondly, complainers can, by using aggressive legal assistance, harassment, intimidation, threat of law suit, etc. very rapidly discourage individual efforts to do a proper job; Thirdly, the end result of a long and unnerving peer review process may culminate in nothing more than expulsion from the society (or the member drops the membership thereby terminating the societies' right to pursue) if the higher authorities (ie, licensing agencies and hospital governing bodies) will not resolve a problem with perseverance and dispatch, therefore leaving the public no better off than before the county peer review decision.

Membership continues to be a problem and this year the total membership dropped. Too many physicians choose not to be a member of organized medicine. Besides the usual complaints of excessive dues, relative inaction, three layers of bureaucracy, and unified membership, we experienced the additional anti-membership factors of building fund dissatisfaction and factorial attitudes regarding distances and peer review problems.

Recommendations:

1. That the House of Delegates strengthen the peer review mechanisms by adopting the proposed changes in the HMA bylaws.
2. That a task force be appointed by the HMA Council, including members of the component societies, and they be mandated to review the responsibilities and functions of the various county societies in their relationship to HMA as well as HMA's relationship to these component societies and report by next year's annual meeting.

RICHARD O. LUNDBORG, M.D.

Commission on Continuing Medical Education

ACTION: Approved

Purpose

The purpose of the Committee on Continuing Medical Education is (1) to accredit medical institutions and societies for Continuing Medical Education credit according to guidelines from the American Medical Association; (2) establish standards of Continuing Medical Education and encourage the development of programs of high quality; and (3) coordinate and publicize Continuing Medical Education activities within the State of Hawaii.

Activities

During the past year, the Continuing Medical Education Committee met on a monthly basis, and was involved with the resurvey and reaccreditation of Hilo Hospital, the Hawaii Thoracic Society, Kauaikeolani Children's Hospital, Kapiolani Maternity and Gynecological Hospital, and Kuakini Medical Center. Several other resurveys are scheduled for the remaining months of 1977.

A subcommittee on standards was established to clarify the criteria for Category I credit. Several sessions were devoted to discussion of CME standards in an attempt to arrive at a uniform approach by the survey teams.

A subcommittee on record keeping was established to organize a system of recording Category I credit for physicians who participate in the accredited programs within the State. Records were accumulated from the beginning of 1977, and the system is presently undergoing further refinement.

A budget subcommittee was also established to correlate the financial aspects of the CME Committee.

Continuing Medical Education requirements for HMA membership were established and forwarded to the HMA Council. The requirements are essentially those of the AMA-PRA Award. An HMA Award was also established which will be valid on a yearly basis, and the requirements are $\frac{1}{3}$ of the credit hours required for the AMA-PRA Award. The effective date for this requirement was recommended to be January 1, 1979.

The Committee through the HMA President communicated with the Board of Medical Examiners regarding the CME requirements for HMA membership as was requested by the Board of Medical Examiners.

CME programs within the State were published monthly in the Journal of the Hawaii Medical Association.

The Committee successfully opposed Senate Resolution 193 pertaining to establishment of the Executive Committee of the College of Health and Sciences and Social Welfare, University of Hawaii, as the body to assess licensing and Continuing Medical Education, and possible re-examination as related to physician competence.

Future Plans

The Committee plans to continue to upgrade the standards of Continuing Medical Education and will seek to encourage all qualified institutions within the State to become accredited in order that physicians may more easily avail themselves of Continuing Medical Education.

The record keeping system will be refined to the point where a physician may easily acquire documentation of the number of credit hours he has accumulated at any one time.

The Committee will continue to serve as an accrediting body for CME credit for the State of Hawaii.

EDGAR HO, M.D.

Resolution No. 1

ACTION: Adopted

Re: Continuing Medical Education

Be it *resolved*, that Continuing Medical Education be a requirement for HMA membership beginning January 1, 1979 as detailed below:

- I. A current AMA-PRA award is satisfactory evidence that the individual has participated in required continuing medical education.
- II. A current HMA-PRA award is satisfactory evidence that the individual has participated in required continuing medical education. This award may be given on an annual basis and the following requirements for its presentation are necessary:
 - A. A total of 50 credit hours per year in any category with the exception that there must be 20 credit hours of Category I credit.

Public Health Commission

ACTION: Approved as amended with recommendation that Dr. Paul Condit and members of the Cancer Committee be commended for their diligence.

The Commission on Public Health includes the Public Safety Committee, Sports Medicine Committee, Crippled Children Committee, School Health Committee, Cancer Committee and Communicable Disease Committee. These reports are printed below:

Public Safety Committee

During the past year, the chairman has served as a resource person for the City Council Committee on Dog Control. The committee has had only one meeting and that was regarding medical examinations for scuba divers. Recommendations were made regarding this.

TRUETT V. BENNETT, M.D.

Sports Medicine Committee

The Sports Medicine Committee met several times during 1977 focusing on a seminar for athletic trainers and coaches, deficiencies in reporting of school athletic injuries, and the possibility of acquiring more athletic trainers for Hawaii. The Sports Medicine Seminar, held on April 29 at McKinley High and organized by Drs. Virgil Jobe and Robert May, attracted several participants. Dr. Robert Nemechek looked into various deficiencies in school athletics and felt that an important area of concern was injured players returning to play without the consent or knowledge of the team physician. Dr. Nemechek offered to devise a form whereby coaches and trainers could record injuries and follow-up that was done. A three part draft reporting form was presented by Mr. Bill Smithe, Executive Secretary of the OIA, at the March meeting of Athletic Directors, however, no follow-up has been done on developing that form.

The committee also discussed the possibility of the state obtaining at least two athletic trainers who could be centrally located having access to rehabilitation equipment. These trainers could also act as a registry for recording injuries in a particular school district or districts. A second idea involved having a traveling athletic trainer who could utilize rehab. equipment in a mobile unit supplemented by school equipment. The committee asked that Mr. Pete Howard and Mr. Glenn Beachy, athletic trainers for Punahou and Kamehameha Schools respectively, to outline the type of program that might be acceptable to the state so that the committee might lend strong support for state appropriations for athletic trainers.

It is hoped that next year's committee will continue to follow-up on the proposals made this year with emphasis directed toward their implementation.

EDWARD KAGIHARA, M.D.

Crippled Children Committee

The Crippled Children's Committee met only once during 1977. Current fee schedules for physician consultants who visit the neighbor islands being utilized by the Crippled Children Branch were discussed. The committee felt that CCB should offer both fee for service and hourly rates to these consultants rather than attempt to standardize the plan for payment.

Incomplete pediatric evaluation reports were also brought up by Dr. Phyllis Wright. The Crippled Children's Committee encourages all physicians to send *complete* evaluation reports so that proper evaluations can be made on the patient.

D. V. REDDY, M.D.

School Health Committee

The School Health Committee met on four occasions and took the following actions:

School Health Service Pilot Program

Members of the committee testified before the State Legislature to make the School Health Service Pilot Program into a permanent one and that the project be expanded into all the schools in the State. The legislature appropriated funds for the expansion of the program to all the public schools in the State although it was not made into a permanent one.

Signing of Form 14

Through the Attorney General's office it was learned that the chiropractors may not sign Form 14 which is the complete student's health record used by the public schools.

Health Education

Ways to have a comprehensive school health education in the public schools were discussed. The committee supported a recommendation that health education be included as a

required curriculum for future elementary school teachers prior to graduation from the University of Hawaii.

Scoliosis Screening

The committee supported the concept of a scoliosis screening program at Grade Six in Physical Education classes in Hawaii's schools.

Medical Home for Every Child

The committee recommended to the School Health Branch of the Dept. of Health to look into the possibility of making sure that each child has a "medical home" and report back to the committee on the logistics of such a project.

Children's Health Services

The committee supported the proposed reorganization of this service as proposed by Dr. Allan Oglesby.

Learning Disabilities Clinic Referral

The committee reviewed the 11 parts outlined in the Learning Disabilities Clinic Referral Criteria and stressed that physician participation is important for the comprehensive health care of the child.

Recommendation:

That the House of Delegates approve the concept of a comprehensive School Health Education program being taught in all the schools of Hawaii.

FERNANDO ATIENZA, M.D.

Cancer Committee

The Cancer Committee met on many occasions to try to resolve the following questions:

What is the function of the Cancer Center in relationship to HMA and the community? A guideline was forwarded to the HMA Council for approval.

What are the duties and responsibilities of the Executive Board of the Cancer Center—if it is only advisory and not truly executive, then HMA should withdraw from the Executive Board of the Cancer Center. This was later resolved by representatives of the HMA, Executive Board of the Cancer Center and University of Hawaii with the conclusion that the Executive Board is executive in function.

Where should the Tumor Registry be located? The action taken by the committee and referred to the HMA Council was that HMA seriously consider moving the Tumor Registry to the proposed Cancer Center of Hawaii Building if satisfactory answers to the following are provided:

- (1) Functions of the Executive Board of the Cancer Center be clarified;
- (2) Role of the Cancer Commission be clarified;
- (3) Clarifications of the fiscal arrangements between the Tumor Registry and HMA;
- (4) Assurance that confidentiality of data will be maintained.

The committee also advised the HMA Council not to support the revised CBCCP because it failed to address itself to the specific problems previously identified. It voted to recommend to the HMA Council support of Queens Medical Center's request for the acquisition of a high energy radiation therapy device and new Radiation Therapy facility.

Recommendation:

1. That the Cancer Committee continue its active role in programs relating to the CBCCP, Cancer Center, Tumor Registry & Community Health Planning.
2. That the community have input to the Cancer Center through the Executive Board of the Center and that the Executive Board exercise their executive prerogatives.

PAUL T. CONDIT, M.D.

Communicable Disease Committee

During the last year the Communicable Disease Committee decided that there is insufficient justification to recommend that S & S screening prior to marriage be discontinued.

From June through August there was a rubella epidemic in Hawaii. The Communicable Disease Committee worked closely with the Epidemiology Branch of the DOH and Dr. Scott Halstead of the University of Hawaii School of Tropical Medicine in maintaining surveillance of this epidemic. Position papers and statements were prepared jointly concerning:

- (a) an immunization campaign for susceptible individuals including Rubella immunization guidelines;
- (b) educational efforts for private physicians;
- (c) preparation of two 20 minute tapes for Oceanic Cablevision;
- (d) recommendations for management of vaccinees who become pregnant within 3 months after receiving the vaccine;
- (e) recommendations for management of pregnant women;
- (f) recommendations for management of suspect rubella.

There was dialogue with representatives of the major laboratories in the islands concerning rubella testing standardization. It was decided to support proficiency testing for local labs on a volunteer basis by the Department of Health.

ROBERT LA FIA, M.D.

ROY KUBOYAMA, M.D.

Emergency Medical Services

ACTION: Approved with the recommendation that EMS work with the HMA Legislative Committee to obtain the Legislation that would provide alternate funding for the program.

I. The Oahu Emergency Medical Services Program Status Summary of HMA-EMS Program as of June 30, 1977

During the past three years, the City & County of Honolulu and the Hawaii Medical Association (HMA) have received funding from Emergency Medical Services Systems (EMSS) Act of 1973 (as amended by the Emergency Medical Services Amendments of 1976) to develop a basic life support system and expand the Basic Life Support (BLS) system into an Advanced Life Support (ALS) system for the Island of Oahu. This system includes the advancement of the 15 mandatory legislated components and the development of an EMS organizational unit.

The EMS system being developed for the Island of Oahu is an areawide system progressing toward full implementation of an ALS system. Because of the geographical peculiarities of the State of Hawaii (its non-contiguous boundaries, both intrastate and interstate) it is essential that a complete advanced life support capability be established on Oahu. It takes from 6 to 12 hours to transfer a patient, from the time a decision is made for transfer, to San Francisco or Los Angeles; therefore, all emergency care must be provided within the State of Hawaii. Most of the highly specialized critical care units are on the Island of Oahu, thereby making coordination and cooperation with the Neighbor Island counties (Kauai, Maui and Hawaii) essential.

During the past three years, under U.S. Department of Health, Education and Welfare funding, great strides have been made in improving the emergency medical care available on the Island of Oahu. However, it is important that these efforts continue and an advanced life support system be fully developed on Oahu. Once the advanced life support capability is fully developed on Oahu, it can serve as a means of backup to the Neighbor Island county systems.

II. Status Summary of HMA-EMS Executive Board Meetings for the Period July 1, 1976 - June 30, 1977

The HMA-Executive Board met the fourth Tuesday of every month during the grant year and discussed major programmatic activities and provided overall policy direction to the program. The membership of the board was as follows: 5 voting members (3 members representing the Hawaii Medical Association; 1 member representing the State Department of Health and 1 member representing the Hawaii Hospital Association). In addition, there were 5 non-voting members (1 member representing the HMA-EMS Program; 1 member representing the City & County Department of Health; 1 member representing the State Health Planning & Development Agency; 1 member representing the Hawaii Medical Association; and 1 member representing the State Department of Health - EMSS Branch). As required, representation from Emergency Room Physicians was sought on an invitational basis. The HMA-EMS Executive Board reported directly to the Hawaii Medical Association's Council. Pertinent agenda items discussed over the past year included:

- Report From the Task Force (Assumption of Program Activities Following June 30, 1977)
- MICT Handbook of Emergency Medications
- C.A.C.I. Evaluation Proposals
- Esophageal Obturator Airway Insertion
- Establishing Criteria for the EMT/MICT versus MICT/MICT Ambulance Unit
- MICT Retraining—Criteria Enforcement
- Proposal From American Samoa and Saipan for prospective trainees to attend Oahu EMS Training Programs
- MAST Trousers for Ambulance Units
- Agreements with Emergency Room Groups for MEDICOM
- EMS Requirements for Maintenance of MICT Certification
- HMA-EMS Program's Emergency Room Physicians ACLS Training
- Additions to the MICT Drug Supply List
- Establishment of I-2 MICT Ambulance Units in Waikiki
- Report of the MICT Drug Subcommittee
- Revision of MICT Standing Orders
- HMA-EMS Program's MICT Training Compliance with EMT-Paramedic Standards
- Preliminary Financial Support Arrangements for Fiscal Year 1979
- MICT Standard Operating Procedures
- EMS Grant Applications for 1978 Funding
- MICT Continuing Education Requirements
- Establishment of a State Paramedic Association
- Letter of Indemnity for Training Programs
- Study—Selected Patient Outcome (Medical and Financial) Related to Oahu EMS System Intervention
- Copyrights for MICT Medical Booklet and MICT Standard Operating Procedures
- Monthly EMS Program Reports
- Financial Reports

III. EMS Schedule of Activities to be Accomplished During the Period July 1, 1977 - June 30, 1978

In order to assure the continuation of the Oahu EMS system, additional finances were sought by the City & County of Honolulu under Public Law 93-154 and 94-573, Title XII, Section 1204, for Oahu EMS expansion and improvement from the Department of Health, Education and Welfare. On July 5, 1977 the City & County of Honolulu received Notice of Grant Award totaling \$784,810 of which a large portion of the implementation was to be subcontracted to the Hawaii Medical Association to further improve the EMS system on Oahu.

The project is considered to be the range of all activities associated with the expansion and improvement of the operation and delivery of ALS to the populace of Oahu. This will be

accomplished by completion of the following by June 30, 1978.

- training of one class of Emergency Medical Technician-Ambulance (EMT-A)
- training of fire, lifeguard, and police personnel in EMS First Responder courses
- training of Mobile Intensive Care Technicians (MICTs)
- training of MICT-Assistants
- training of Emergency Room Nurses
- training of Critical Care Nurses (e.g., ICU RN's)
- training and continuing education of Emergency Room Physicians
- re-examination and analysis of hospital vertical categorization
- continuation and expansion of the evaluation component in relation to the evaluation workbook
- enhancement of the data processing system for ambulance generated data
- expansion of the UHF radio communications system to include the lifeguard agency
- comprehensive evaluation of the current MEDICOM (medical communication) system
- consolidation of the Public Information and Education component for future continuation after the completion of federal funds
- contracting of program clinical group consultants:
 - Dr. Samuel Gresham Cardiac
 - Dr. Edward Chesne
 - Dr. William H. Hammon Spinal Cord Injuries
 - Dr. Thomas J. Whelan, Jr.
 - Dr. Gabriel W.D. Ma Trauma
 - Dr. James H. Penoff Burns
 - Dr. Michael John Light Perinatal
 - Dr. Jon Mark Streltzer Behavioral Disorders
 - Dr. Richard K.B. Ho Poison
 - Dr. Kenneth Grant Maternal and OB-Gyn
- complete a review and evaluation of current courses being provided on Oahu for lay person cardiopulmonary resuscitation (CPR)
- update financial plan and commitments for continuation of the Oahu EMS system following the termination of federal grant funds (which is anticipated to occur on June 30, 1978).

IV. HMA-EMS Program Approximate Expenditures for Neighbor Islands as of February 18, 1977

I. TOTAL INCOME FROM ALL GRANTS, ALL SOURCES TO HMA-EMS PROGRAM: \$3,723,795.26 (INCLUDES INDIRECT COSTS)	
II. NEIGHBOR ISLAND EXPENDITURES* PROVIDED FOR BY HMA-EMS PROGRAM:	
• MEDICOM (Phase II)	\$572,285.00
• Neighbor Island Emergency Medical Technician—Ambulance and Mobile Intensive Care Technician Per Diem and Airfare	74,034.23**
• Emergency Medical Technician Training, 79 at \$1344.00 each	106,176.00
• Mobile Intensive Care Technician Training, ***24 at \$1615.35 each	38,768.40
• Ambulances—3 at \$22,000 each	66,000.00**
• EKG Monitor/Defibrillators 13 at \$4265.48 each	55,451.24
• Emergency Room Nurses Training, 12 at \$965.00 each	11,580.00
• Contracted State Department of Health-Emergency Medical Services Neighbor Island Planning Grant	70,416.00****
TOTAL EXPENDITURE: \$994,710.87*****	

*Expenditures are approximate and exclude costs for training Neighbor Island physicians, costs for training materials sent to the Neighbor Islands for Emergency Room Nurses training, costs for HMA-FMS Program categorization of Neighbor Island hospitals, costs for HMA-EMS Program development of Neighbor Island Emergency Room/Ambulance forms, HMA-EMS Program development/implementation of Neighbor Island computerized forms.
**Approximate expenditures listed here
***Includes 21 Neighbor Island working MICT's; 2 MICT's as instructors for State Department of Health on the Neighbor Island (H.H.O.); and 1 MICT as administrator for State Department of Health—FMSS (for the Neighbor Islands).
****Excludes indirect costs. (Grant for Neighbor Island only, Grant #09-P-000776-01-0 MS-P35-N).
*****This total would be the lowest amount of expenditures for the Neighbor Islands.

III. EXPENDITURES (NEIGHBOR ISLANDS) DIVIDED BY TOTAL INCOME × 100 = HMA-EMS PROGRAM EXPENDITURES FOR THE NEIGHBOR ISLANDS:

$$\frac{\$ 994,710.87}{\$3,723,795.26} \times 100 = 26.7\% \text{ for Neighbor Islands}$$

IV. HAWAII CIVILIAN RESIDENT POPULATION COMPARED TO FOCAL EXPENDITURE

		EXPENDITURES BY HMA-EMSP
POPULATION		
OAHU	82%	73.3%
NEIGHBOR ISLANDS	18%	26.7%
TOTALS:		100%

The following information details the HMA-EMS Program's expenditures for the MEDICOM System as of February, 1977:

PROJECT	
PHASE I (OAHU)	\$ 304,442.22
PHASE II (NEIGHBOR ISLAND, STATEWIDE LINK*)	572,285.00
1203—Department of Health, Education and Welfare/Emergency Medical Services (7/1/74 - 6/30/75 to HMA-EMS Program)	
	311,787.00
TOTAL EXPENDITURES:	
	\$1,188,514.22
NEIGHBOR ISLAND EXPENDITURES (PHASE II)	
	\$ 572,285.00 = 0.48
TOTAL EXPENDITURES	
	\$1,188,514.22
% NEIGHBOR ISLAND EXPENDITURES OF TOTAL = (0.48) (100) = 48%	
(% NEIGHBOR ISLAND RESIDENT CIVILIAN POPULATION OF TOTAL HAWAII CIVILIAN POPULATION = 18%)	

EQUIPMENT FOR MEDICOM				
Area	# Base Stations**	# Repeater Sites	# Hosp. ER** Medicom Units	# Cor Units
OAHU	16 (inc. 5 statewide)	8	11	14
HAWAII COUNTY	7	4	5	0
MAUI COUNTY	5	3	4	0
KAUAI COUNTY	4	5	2	0
STATE TOTAL:	32	20	22	14
OAHU TOTAL				
	16 (50% of State Total)	8 (40% of State Total)	11 (50% of State Total)	14 (100% of State Total)
NEIGHBOR ISLAND TOTAL	16	12	11	0

This compilation is subject to audit by Stanly E. Harter (EOC), Motorola, Incorporated, Hawaii Medical Association and the Department of Health, Education and Welfare (EMS).

*The Statewide link at Puumanawahua was expenditure of approximately \$31,376.81.
**Generally hospital Emergency Room MEDICOM comprise a base station.

The following lists a breakdown of persons trained in Hawaii Medical Association—Emergency Medical Services Program (HMA-EMSP) Training Programs from January 1, 1972 - June 30, 1977; State totals, Oahu totals, and Neighbor Island totals. (See Table entitled "Persons Training in Hawaii Medical Association—Emergency Medical Services Program (HMA-EMSP) Training Programs".)

Members of the HMA-Executive Board to the EMS Program for 1977 are:
Dr. Livingston M.F. Wong, Chairman, since July 1, 1977
Dr. William W.L. Dang, Chairman, January 1, 1977 - June 30, 1977
Dr. Stanley M. Saiki
Dr. David Eith
Mr. Henry Thompson
Mr. Paul Cook

LIVINGSTON M.F. WONG, M.D.

Budget Requests:

MICT Graduations	\$ 1,200.00/year
Legal Fees	10,000.00/year
Interim Financial Support for EMS	40,000.00 (FY 1979)

PERSONS TRAINED IN HAWAII MEDICAL ASSOCIATION—EMERGENCY MEDICAL SERVICES PROGRAM (HMA-EMSP) TRAINING PROGRAMS FROM 1/1/72 - 6/30/77: STATE TOTALS, OAHU TOTALS, NEIGHBOR ISLAND TOTALS

Compiled September 23, 1977

A	B	C	D	E	# Trained for Oahu Versus Neighbor Islands (Breakdown of Column D)					
					Total # Trainees & % Fail/Drop /Incomplete	Total # Trainees Oahu # Pass %	Total # Trainees Neighbor Island # Pass %	Total # Trainees Out of State # Pass %		
HMA-EMSP TRAINING PROGRAM										
Lay Person Cardiopulmonary Resuscitation (CPR) ¹	12-16	Summer '75	5	0	5	100%	—	—	—	—
Lay First Responder Course ¹	40	Summer '75	1	0	1	100%	—	—	—	—
Police First Responder (F. R.) ²										
CPR	12	4/75	314 (30% of total	0	314	100%	—	— ¹⁰	—	—
First Responder	14-24		314 to be trained)	0	314	100%	—	—	—	—
Firefighter First Responder ³										
CPR	12	12/74	947 (100% of total)	0	947	100%	—	— ¹⁰	—	—
40 hr. First Responder	40		246 (26% of total)	0	246	100%	—	—	—	—
Lifeguard (Ocean) First Responder ³										
BLS CPR	12	11/74	63 (100% of total)	0	63	100%	—	— ¹⁰	—	—
40 hr. First Responder	40		63 (100% of total)	0	63	100%	—	—	—	—
Emergency Medical Technician- Ambulance (EMT-A) ⁴	400	11/71	298	28 (8%)	217	73%	81	27%	—	—
Mobile Intensive Care Technician Assistant ⁵	320	7/76	19	6 (24%)	19	100%	—	— ¹⁰	—	—
Mobile Intensive Care Technician (Paramedic) ^{5,6}	1215	9/72	99	56 (36%)	71 ⁶	75.5% ⁶	23 ⁶	24.5% ⁶	—	—
Emergency Room Registered Nurse ⁷	120	4/73	169	0	156	92%	13 ¹¹	8%	—	—
Intensive Care Unit Registered Nurse ⁷	120	9/75	89	0	87	90%	2	2%	—	—
Emergency Room Physician (Variable) ⁸										
○ Hawaii ER Physician Seminars	variable	7/73	N.A.	N.A.	average 34 (91%)	average 2.5 (9%)	—	—	—	—
					Total Oahu Attending Cumulative-495	Total N.I. Attending Cumulative-35				
○ BCLS 1-2-3-4-5	8	1/77	50	3 (6%)	46	96%	2	4%	2	4%
○ ACLS	14	2/77	48	1 (2%)	44	92%	2	4%	2	4%

Hawaii Resident Population (excluding military, 1975)⁹ total 864,900, Oahu 704,500=82%; N.I. 160,400=18%
All figures and percentages compiled from HMA-EMSP Training Staff Statistics (excepting the Hawaii Resident Population Figures)

LEGEND FOR 1/1/72 - 6/30/77 TRAINING PROGRAM TABLE

1 not a formal training program of HMA-EMSP for any grant period
2 training has variable, depending on time made available by the Honolulu Police Department (HPD): CPR is included (12 hrs. of Basic Life Support, CPR); Crash Injury Management Guidelines are used partially; HPD= 1050 field police (1490 total includes administrative personnel)
3 program approved by OSHA State of Hawaii; includes American Heart Association BLS CPR 1-2-3-4 Certification, Lifeguard Service (94 total, 88 field with 63 full time); Honolulu Fire Department (947 total personnel with 898 field)
4 approved by National Registry of Emergency Medical Technicians; training described Hawaii Medical Journal 3:227-232, 1976
5 approved, Board of Medical Examiners, State of Hawaii
6 excludes MICT's as policemen (1), administrators (1), or full-time teachers (3) for island computations (N= 94 for island computations, not 99)
7 approved, Hawaii Nurses Association
8 excepting Hawaii Emergency Physician Seminars (HEPS) 1, 2, and 3, all remaining activities approved for Category I Physician CME Credits from A.M.A. and A.C.E.P.; 7 HEP Seminars, 5 Basic Life Support CPR Certification Courses, 4 Advanced Cardiac Life Support Certification Courses; 7 HEPS (495 Oahu M.D. visits, 35 N.I. M.D. visits); BCLS= Basic Cardiac Life Support CPR Certification. ACLS= Advanced Cardiac Life Support Certification
9 from Department of Planning and Economic Development: The Population of Hawaii 1958-2025, Statistical Report #114, Table A-2 (Total Resident Population) p. 10, State of Hawaii
10 not offered by HMA-EMSP to N.I. personnel since grants were restricted to Oahu
11 seven (7) of these Neighbor Island R.N.'s were trained to be instructors for the ER R.N. Course for each Neighbor Island

Additional References:

- Chinn HYK: Emergency Medical Services—Hawaii, *HAWAII MEDICAL JOURNAL* 32:240, 1973.
- Chinn HYK: Emergency Medical Services Program, *HAWAII MEDICAL JOURNAL* 33:477-479, 1974.
- Sims JK, Akina S, Dods V, et al: The Emergency Medical Services Program of Hawaii. Part II. Emergency Medical Technician (E.M.T.) Training of Hawaii's Ambulance and Rescue Personnel. *HAWAII MEDICAL JOURNAL* 35:227-232, 1976.
- Dang W: Emergency Medical Services, *HAWAII MEDICAL JOURNAL* 34:439, 1975.
- Sia CCJ: The Oahu Emergency Medical Services Program. *HAWAII MEDICAL JOURNAL* 35:403-405, 1976.
- Sims JK, Wright LM, Gavin JA, et al: The Emergency Medical Services Program of Hawaii—I. General Overview. *HAWAII MEDICAL JOURNAL* 35:49-51, 1976.

Commission on Health Service and Care

ACTION: Approved

The Commission on Health Service and Care consists of three committees which were active during the year: Community Health Care Committee, Health Manpower Committee, and Disaster Committee. The reports of these committees are reprinted below:

WILLIAM W.L. DANG, M.D.

Community Health Care Committee

Activities to fully implement Public Law 93-641 have finally moved into high gear, and the various state organizations and agencies are being kept very busy trying to oversee this area of community health planning. All eight of the Subarea Councils (SAC), the State Health Coordinating Council (SHCC), and the State Health Planning and Development Agency (SHPDA) are fully appointed and very busily involved in their many activities.

From the beginning of this year, it has been obvious that the Hawaii Medical Association has got to become more deeply involved in these extensive health planning activities for the community. It must somehow develop a higher profile and a more conspicuous voice in speaking on behalf of the physicians in these matters that touch all of us.

The initial effort was made to organize this concept for HMA. Many of us had to become "educated" about these concepts and had to learn a new language. More importantly, physicians had to be organized into a meaningful group, so that controversy and individuality could be minimized, and hopefully, a single voice could manage to speak on behalf of the physicians in the community.

Accordingly, the first few meetings were spent trying to acquaint the physicians on the committee with the monstrous nature and responsibilities of the tasks ahead. It was finally agreed that all of the medical specialty organizations should be contacted and invited to join this committee's activities. Dr. Ann Catts, President of the Honolulu County Medical Society, was also invited to join the discussions.

Currently, the meetings are open, communications have been improved, and we are finally beginning to develop some confidence that the committee is beginning to function adequately.

The following subjects were discussed at the meetings this year:

- (1) **State Health Goals for Comprehensive State Health Plan**—Committee discussed and adopted a modified version of the goals submitted to us by SHPDA. Goals were approved by HMA Council and forwarded back to SHPDA.
- (2) **Proposed Certificate of Need Rules**—Discussed and forwarded suggestions to SHPDA for modifications. Currently, confronting second drafting of Rules and open hearings by SHPDA.

- (3) **SHPDA Policies and Criteria for Certificates of Need for Computed Tomography Scanners**—Discussed and forwarded suggestions for modifications to SHPDA.
- (4) **Request for Support of Certificate of Need for the Acquisition of a High-Energy Radiation Therapy device and new Radiation Therapy Facility (Queen's Medical Center)**—Discussed and approved support for concept. Forwarded to HMA Council for action.

The Future—Hopefully, the base for operations for this most important activity for HMA can be more firmly established.

Although there is still a question as to whether PL 93-641 will survive the rigors ahead, one cannot doubt that health planning is a political and social reality which must be constructively considered now and in the future. HMA must devote its energies to this basic concept of health planning in the community.

For the next year, the major task ahead for health planners will be to adopt a Comprehensive State Health Plan that can be acceptable to the Department of Health, Education, and Welfare (DHEW). The work is being intensively pursued in the SACs currently, and the first draft of the proposals will be ready for circulation and discussion by January 1978. HMA will have to organize to confront this problem next year, and this committee conceivably should play a major role in developing this activity for physician member input and reactions, as well as to keep the membership informed and abreast of these developments.

It is also suggested that some method should be developed to ensure that the various county medical societies share in the appointments to this group in the future.

Recommendations:

- (1) That HMA become actively involved in the development and adoption of the State Health Plan,
- (2) That HMA keep its members informed and abreast of these health planning activities, and
- (3) That some method be developed to allow county medical societies to share in appointment of this committee.

DONALD F.B. CHAR, M.D.

Health Manpower Committee

The Health Manpower Committee met on three occasions during the year. A major item of discussion was the Medical Laboratory Technician (MLT) Program at Kapiolani Community College (KCC). The committee met with Mrs. June Kuroda, Instructor of the MLT Program at KCC, and learned of the University of Hawaii's budget squeeze and uncertainty surrounding the continuation of the MLT Program. Since the Committee felt that the MLT Program and other allied health educational programs should be supported as a means of assuring the community of continued service by these professions, a letter was written to Fujio Matsuda, President of the University of Hawaii, to share the HMA's concern with regard to support of the MLT Program. The Committee was later assured by President Matsuda that there is no effort by the University to eliminate the MLT Program. It was explained that the MLT Program is one of the ten allied health education and nursing programs initiated under the auspices of Federal grants and that careful program review is being conducted in order for these programs to continue under full State funding. As an alternative, the College administration has considered the possibility of offering the MLT Program on an alternating year basis.

Discussion also occurred with Dr. Jerrold Michael, Dean of the University of Hawaii School of Public Health, as to the possibility of developing physician manpower statistics. Dr. Michael briefed the committee on sources of information available and enlightened the committee on Public Law 94-484, the Health Professions Educational Assistance Act of 1976, which could have an impact on health manpower as it places greater restrictions on foreign born medical graduates.

The committee, however, did not develop definitive guidelines for collection of physician manpower data in Hawaii.

Recommendation:

That the Health Manpower Committee continue to monitor health manpower needs of the State and keep abreast of national legislation affecting this area.

WILLIAM F. MOORE, JR., M.D.

Disaster Committee

The Disaster Committee met jointly with the HCMS Disaster Committee and discussed participation in the 1977 Oahu Disaster Exercise, which involved various City and County of Honolulu agencies, Metropolitan Disaster Response agencies, and appropriate military activities. The committee provided assistance in triage and evaluation of the exercise.

Recommendation:

That the Disaster Committee continue to assist the counties in disaster exercises.

DAVID T. EITH, M.D.

Ad Hoc Cancer Center Liaison Committee

ACTION: Approved

The primary purpose for establishing the Ad Hoc Cancer Center Liaison Committee was to create a forum to discuss and clarify the HMA's position on matters concerning cancer by combining elements of the HMA involved with this subject such as the Cancer Committee, Cancer Commission, and Cancer Center of Hawaii Representatives.

The Committee met on seven occasions during the year. Discussion took place on the role of the CCH Executive Committee, Hawaii Tumor Registry, Community Based Cancer Control Project, and bills pertaining to cancer which were introduced during the 1977 Legislative session. The meetings were generally of an informative nature and perhaps aided the committee and commission chairmen in conducting business within their committees and CCH representatives in speaking for the HMA on the CCH Executive Committee.

As the Committee was relatively inactive during the latter part of this year, it is recommended that it be continued but that it meet only at the request of the President to address itself to the problems presented to it by the President.

CALVIN C.J. SIA, M.D.

AMA Delegate

ACTION: Approved as amended with congratulations to Dr. Mills on his recent appointment to the AMA Board of Trustees.

The 126th Annual Meeting of the AMA was held June 19 through 23 in San Francisco.

Briefly discussed are some of the items included as business at the meeting.

The delegates voted continued support of the "Comprehensive Health Insurance Act." This AMA sponsored bill is included in HR 1818 and S 218 of the 95th Congress.

Regarding Laetrile the House stated that "Laetrile has no proven value as a drug."

The delegates supported the concept of over the counter sale of saccharin with a warning that it can cause cancer of the bladder in certain experimental animals.

The delegates supported report A of the Judicial Council. "... mercy killing or euthanasia is contrary to public policy, and medical tradition ..." "the cessation of the employment of extraordinary means to prolong the life of the body when

there is irrefutable evidence that (biological) death is imminent is the decision of the patient and/or his immediate family."

The council on Long Range Planning report that there be direct specialty society representation in the House of Delegates was referred to the Board of Trustees for study and development of a plan for implementation.

The delegates supported the preliminary draft of guidelines for the expert witness. A few states (3) have passed laws that outline the requirements necessary for a physician to qualify as an expert. This is an important and very sensitive issue within our profession. I would strongly recommend that the Hawaii Medical Association study the issue and prepare material so that this problem can be discussed at our annual meeting in October 1977.

There was a great deal of discussion regarding rotating residences. There was concern that too many young physicians go directly into specialty or subspecialty training and consequently are not aware of the broad scope of medical care. It was recommended that the issue of rotation through the services be studied for possible reinstitution.

The delegates did not accept a report which recommended that the AMA have a full time president. This issue has many points pro and con and definitely will be an issue for delegates' deliberation at future meetings.

The delegates support Report CC of Board of Trustees which recommend (1) After the 1978 Annual Meeting of the AMA there will no longer be an educational or scientific component associated with the Annual Meeting. Scientific programs will be conducted throughout the year as is being done at present with the Regional Scientific Programs and the Winter Scientific program.

(2) The Board of Trustees will have the prerogative to choose the time and site for the summer and winter sessions of the AMA House of Delegates. In the past the House ratified the B.O.T. recommendation. It was suggested in the discussion of this issue that the summer meetings be held in Chicago and winter meetings in the areas of the country where the weather can be expected not to be so severe and wintry, such as Hawaii. Now that this policy is set, the Hawaii Medical Association should request confirmation from AMA for another winter meeting in Hawaii.

The delegates requested that the B.O.T. and the council on legislation pursue the enactment of national legislation that will allow the continued use of R.V.S. The AMA and all physicians must be vigilant and oppose any legislation or Federal rules or regulation that provides unilaterally (without practicing physician input) that HEW or any other government agency can establish a separate R.V.S. for covered services in any government sponsored program.

Present discussion by government of reimbursement for the "professional component" of a procedure or service must also be monitored very closely.

If this concept is instituted it would create tremendous liability, accounting, payment and review problems for the practicing physician. It could also provide that poorly qualified physician assistants a greater say in the total fee.

The delegates supported the policy that mass screening of school children particularly in fragmented organ system screening programs be undertaken only with the approval of the local medical society.

Since this is my last report as the AMA delegate from Hawaii, I would like to thank the officers, council members and the members of the HEW House of Delegates for the rewarding experience of being their delegate to AMA.

As I leave the Council of HMA and embark on a new area of work in American medicine, I would like to share a few thoughts with you.

The AMA is the only organization which can serve as the umbrella organization for American Medicine. With the relentless and increasing pressure of government intervention in medical care, this issue grows in significance. All physicians in this country must understand this issue clearly.

The next few years will be very difficult for the American physician and his patient. During this time it will be determined whether or not we will enjoy the right to continue as masters of our destiny as independent practitioners of

medicine, or pawns of big government and politicians, many of whom refuse to try to understand what it really means to provide medical care.

We must support every effort to maintain unity. We must keep well-informed scientifically, economically, legally and politically.

A weakening in any one of these four major areas will open the gate for easy government intervention.

I am grateful that I have been allowed to sit as a member of the HMA Council for the past 18 years.

I am grateful for the years you have allowed me the privilege to serve as your representative to the AMA House of Delegates.

Recommendation:

- (1) Communicate to the Governor of the State of Hawaii that the HMA strongly opposes any attempt at fee-setting by SHPDA or any other division in PL 93-641 and that he communicate with the Attorney General as to the legality of this action.
- (2) Since the attempt by the State of Hawaii to implement PL 93-641 rests totally within the parameters of State bureaucracy and politics, it is imperative that the HMA maintain a committee of qualified HMA members to monitor and report to the HMA Council no less than every three months the action of SHPDA and SHCC.
- (3) That HMA's legal representative be contacted for an opinion regarding the legality of fee-setting by SHPDA.

GEORGE H. MILLS, M.D.

Cancer Center Representatives

ACTION: Filed with appreciation to Dr. Thomas Lau, Dr. Andrew Morgan, Dr. Henry Oyama and Dr. Herbert Chinn for serving as the representatives of HMA on the Executive Board of the Cancer Center.

Meetings have been held fairly regularly on a monthly basis, attended by your four representatives. During the year meetings were held with George Yuen from the Department of Health; Reginald Ho, Drake Will and Richard Bunker from the American Cancer Society; President Fujio Matsuda and Chancellor Douglas Yamamura from the University of Hawaii; and Lawrence Piette from the Cancer Center.

Groundbreaking of the Center was held this summer. Funding for the fourth year for the grant would probably be resolved in the very near future.

Two of the incumbent members, Andrew Morgan and Henry Oyama, were reappointed to the Executive Board of the Cancer Center.

Meetings with Gerald Panis, Public Relations, were held in developing a fund-raising drive for the Cancer Center which should probably be kicked off some time next year.

The following are the members of the Executive Board of the Cancer Center:

Jean Hankin, Professor of Public Health, University of Hawaii
Helen Burnside, Dean of the School of Nursing, University of Hawaii
Howard McKaughan, Director of Research, University of Hawaii
Thomas Whelan, Professor of Surgery, John A. Burns School of Medicine, University of Hawaii
Richard Bunker, American Cancer Society
Francis Locke, American Cancer Society
James Yano, Hospital Association of Hawaii
Verne Waite, Department of Health
Thomas Lau, Andrew Morgan, Henry Oyama, Herbert Chinn representing the Hawaii Medical Association

HERBERT Y.H. CHINN, M.D.

Cancer Commission

ACTION: Filed

The Hawaii Tumor Registry continues to operate well in meeting its general obligations and in addition, is satisfactorily fulfilling the requests of persons who have a need for data for individual projects. The Hawaii Tumor Registry continues to participate in the SEER program of the National Cancer Institute. The Council of the HMA voted to move the Hawaii Tumor Registry into the Cancer Center Building when it is completed.

GROVER H. BATTEN, M.D.

Ad Hoc Committee on Child Health Plan PL 93-641

ACTION: Approved

An ad hoc committee was formed to explore the development of a child health plan. Since PL 93-641 focuses on a general health plan there has been some concern for the development of a plan for child health services. Meetings were held with representatives from the Department of Health, the private sector, and the University of Hawaii during the past year and a start of a plan has been initiated.

Contact has also been made with the State Health Planning Development Agency, SHPDA. It is hoped that this can be continued this coming year.

Recommendation: To continue the ad hoc committee to study child health plan under PL 93-641.

CAVIN C.J. STA, M.D.

Resolution No. 3

ACTION: Adopted

Re: Video Center

WHEREAS, the TV-Radio Committee feels that the Hawaii Medical Association should assume leadership in patient participation and patient information, and

WHEREAS, this patient participation and information can ultimately lead to better resource utilization and cost containment, and

WHEREAS, there is an apparent need for facilities and services in facilitating patient education, now therefore be it

Resolved, that the TV-Radio Committee and the Hawaii Medical Association endorse the Video Center project at Kapiolani Hospital as a prototype for patient education.

HENRY N. YOKOYAMA, M.D.

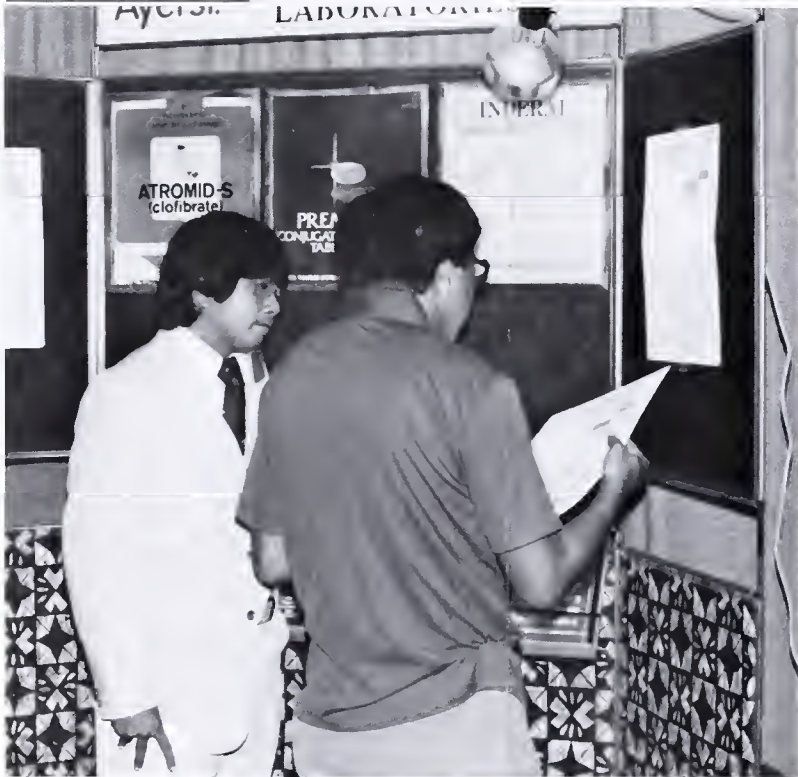
Reference Committee on Miscellaneous Business

Commission on Legislation

ACTION: Approved as amended

Legislative Committee

The 1977 session of the Ninth State Legislature was very active in bills and resolutions relating to health. Working closely with the many committees and commissions of the Association, the Legislative Committee took positions and presented testimony on most of the significant legislative proposals which would affect the medical profession. Anyone interested in any of the actions taken by the Legislative Committee is invited to call Mrs. Becky Kendro, who lives up to our expectation in keeping the committee apprised of the rapidly changing scene in the State Legislature. The active





and willing participation of the staff and many members of the Association in legislative matters in which particular expertise is required is gratefully acknowledged.

The major activity of the Association at the Legislature related to professional liability and amendments to Act 219 which was skillfully guided by our legislative counsel, Mr. Kazuhisa Abe, and by the Ad Hoc Committee on Act 219 chaired by Dr. Leonard Howard.

The following bills relating to the practice of medicine were enacted:

- (1) SB 1059—Relating to medical malpractice and amendments to Act 219 (SLH '76).
- (2) HB 96—Extends the definition of child abuse to include the term "psychological abuse and neglect." Authorizes the director of DSSH to further define the specific forms of child abuse through the adoption and amendment of rules.
- (3) HB 206—Authorizes the director of the Department of Health to assess and collect reasonable fees for the execution of regulatory provisions for ambulance certification.
- (4) HB 676—Grants to the Board of Medical Examiners the power to promulgate rules and regulations.
- (5) HB 727—Adds a new chapter to the law by creating a physician and surgeon "cooperative" which is specifically excluded from Hawaii's Insurance Law.
- (6) HB 1658—Provides for choice in physicians and optometrists for public assistance recipients eligible for eye care assistance. Further provides that applicants for public assistance to the blind must be examined and certified by a qualified physician before approval by DSSH.
- (7) HB 1614—Amends State law to conform to the requirements for Federal funding in health planning and resources development under PL 93-641 and provides for citizen input into health planning via the designation of subarea health councils.
- (8) A provision was incorporated in the DSSH budget which prohibits sexual sterilization of DSSH recipients unless informed consent is obtained two weeks prior to the procedure. This provision was added during the special session of the Legislature without public hearing. We feel this discriminatory provision against the poor should be repealed.

The following bills were filed in committees:

- (1) A bill which would have reduced the physicians' fees under medicaid
- (2) A measure which would have allowed generic substitution.
- (3) A bill which would have placed physicians under the pharmacy board when dispensing drugs.
- (4) A bill allowing the use of laetrile.
- (5) Bills on natural death and living wills.
- (6) A bill which would have mandated a patient's bill of rights in hospitals.
- (7) A bill which would have created a cancer commission under the office of the Governor.

Budget Request:

Legislative Counsel	\$8,500.00
Promotional Activities	1,500.00
Today's Health	300.00
Miscellaneous	400.00
Total	\$10,700.00

Recommendation:

- (1) That the budget of the Legislative Committee be approved.
- (2) That the invaluable services of Mr. Kazuhisa Abe be acknowledged and his services retained for the next legislative session; provided that the HMA Council approves the necessity of retaining a legislative counsel.
- (3) That an Ad Hoc Committee on Act 178 be formed.
- (4) That four representatives from the medical Auxiliary be added to the Legislative Committee.

Pharmacy Committee

The Pharmacy Committee, under the chairmanship of Dr.

Vincent S. Aoki, prepared and presented testimony on the bill relating to generic substitution of drugs.

GEORGE GOTO, M.D.

Ad Hoc Committee to Amend Act 219

ACTION: Approved as amended

The Ad Hoc Committee to Amend Act 219 was formed as a subcommittee of the Legislative Committee to propose amendments to Act 219 (Session Laws of Hawaii, 1976), present the proposal to the Legislators, and lobby for passage of our proposed amendments.

The committee was composed of: Leonard Howard, Chairman; Richard Fardal, Theodore Tseu, Albert Chun-Hoon, William Moore, George Goto, J.I.F. Reppun, Roy Kuboyama, E. Lee Simmons, Bruce Joseph, Helen Percy (Maui), Kenneth Ching (Hawaii).

The committee met weekly from the onset to compile a set of proposed amendments for presentation to the HMA Council. Each proposed amendment received the unanimous approval of the committee.

After approval of the Council, these amendments were circulated to the HMA membership for informational purposes. They were also presented to the chiefs of staff of the various hospitals and when requested, to the Executive Committee of the hospital.

Continued research in committee resulted in a revision of the original proposal. This proposal was presented to the House Policy Committee, the Senate Majority Caucus, and the Senate Minority Caucus. Each member of the House Consumer Protection Committee and House Finance Committee and the Senate Judiciary Committee was contacted individually by a member of the committee and given a copy of the HMA Position Paper on Amendments to Act 219.

These presentations resulted in House Bill 48 and Senate Bill 1059 as well as individual bills in the House and Senate covering each proposal. Members of the committee wrote testimony on the area of the bill which they had researched, and a summary paper was presented in the hearings on the bills held by the appropriate legislative committee.

After the hearings, meetings were held with various legislators in an attempt to preserve as much of the original proposal as possible. It should be noted that continued committee research and meetings resulted in some revision of the original proposals:

Collateral Source provisions were eliminated when it was pointed out in meetings with the Senate members that State law required subrogation, which eliminated the problem.

Compensation of Medical Conciliation Panel Members was withdrawn by the committee after hearing opinions expressed by many legislators that the position of the physicians last year was that we would be willing to serve on the committee. In view of this opinion, it was agreed to increase the number of panelists to 35 physicians and 35 attorneys in an effort to minimize the amount of time each panelist would serve.

Medical Records: After listening to the AMA Legal Counsel and reading many articles relating to patient medical records and the release of records to the patient, the committee withdrew our original proposed amendment regarding medical records and recommended retention of the law as passed last year.

Several changes were made by the Legislature which could not be overcome by our lobbying efforts. Main among these was the change in the law regarding attorney's contingency fees. This year's proposal by both House and Senate was to remove any limitation of contingency fee and substitute obligatory review of all attorney's contingency fees by the trial judge, such review to cover the appropriateness of the fee.

The House was unwilling to accept the Senate version of the bill in toto, and so the bills went to Conference Committee. The result of the Conference Committee was to accept Senate Bill 1059 with the elimination of periodic payment and the medical records proposals. It is of note that there was

considerable interest in periodic payment in the Senate and it was suggested by both committee chairmen that another bill on periodic payment be submitted next year after finding out what the other states are doing with regard to periodic payment and what seems to work well.

The final result was the following package of amendments:

- (1) That section of Act 219 which required insurance for licensure was deleted.
- (2) The requirement of financial responsibility in order to participate in the Patient's Compensation Fund was retained.
- (3) The Patient's Compensation Fund will assume the liability of any claim filed six years after the time of occurrence provided that the physician participated in the PCF at the time of occurrence. This amendment will eliminate the "long-tail" liability, especially for minors, that insurance carriers say require large reserves.
- (4) Corrects the language in Hawaii's Statute of Limitations law (2 years from time of discovery or no more than six years from time of occurrence) and now insures that "this six year time limitation shall be tolled for any period during which the person has failed to disclose any act, error or omission upon which the action is based and which is known to him." Physicians are thus protected from liability after the six-year period unless they fail to disclose any act, error or omission to the patient.
- (5) Increases the number of panelists for Medical Claim Conciliation Panel members to 35 physicians and 35 attorneys.
- (6) Provides a \$1 million limit per occurrence or \$3 million aggregate on claims paid from the Patient's Compensation Fund.
- (7) Allows the insurance commissioner to set levels of participation in the Patient's Compensation Fund depending on the need of the physician for coverage over \$100,000.
- (8) Retains the language of Act 219 which says that a physician must provide a copy of the patient's records to the patient upon request unless he believes that release would be detrimental to the health of the patient in which case the physician may release records to the patient's attorney upon proper authorization for release.
- (9) The bill eliminates any reference to limitation of attorney's fees of specific amounts and states that *all* attorney's contingency fees shall be submitted to the court for an evaluation of reasonableness.
- (10) Eliminates from Act 219, language which physicians believed to be prejudicial and unnecessary ("Impose appropriate sanctions on errant health care providers, recognizing the integral role in this process played by the licensing system; . . .")
- (11) Deleted three conditions for limitation or revocation of medical license as recommended by HMA.

The committee recommends that amendments which will allow for periodic payments be sought next year and that careful attention be paid to the "appropriateness" of the contingency fees paid over the next year. We should also suggest a law that it be a legislative standard to require an expert witness in any malpractice case. We should also continue to monitor informed consent procedures in other states.

I would like to express my personal appreciation and thanks for the many hours of work contributed by the members of the Act 219 Committee. I believe it represents a broadening awareness of the necessity for legislative action in the practice of medicine.

Recommendation:

- (1) That amendments which will allow for periodic payments be sought next year.
- (2) That careful attention be paid to the "appropriateness" of the contingency fees paid over the next year.
- (3) That HMA should suggest a law that it be a legislative standard to require an expert witness in any malpractice case.

- (4) That the committee continue to monitor informed consent procedures in other states.

LEONARD R. HOWARD, M.D.

Ad Hoc Committee on Self-Insurance

ACTION: Filed

The Ad Hoc Self-Insurance Committee met on several occasions throughout the year to investigate alternatives in alleviating the professional liability insurance crisis.

Representatives of Frank B. Hall & Co., Argonaut Insurance Company, Johnson & Higgins, Hawaii Association of Physicians Indemnification (HAPI), David Gordon of Professional Economic Services and Paul Brown who is interested in forming a self-insurance company were interviewed.

Elements of the committee met with Mr. John Savage, President of United Pacific Insurance Company, and many good ideas were obtained from this meeting.

The committee saw fit to endorse the formation of a Hawaii Physician's Cooperative and supported it in the legislature. Endorsement was also given to Mr. Paul Brown to form a stock professional liability insurance company.

The committee would like to give special recognition to John Cavanah who spent many hours meeting with the committee and was a readily source of information and advice.

It is recommended that the committee continue to exist and meet as needed to further evaluate new alternatives or reevaluate older ones previously acted upon. Perhaps this should become a standing committee.

JOHN W. EDWARDS, JR., M.D.

Resolution No. 2

ACTION: A motion was made and seconded to adopt Resolution No. 2. A motion of substitution was made and seconded to substitute the following for the first "resolved" of Resolution No. 2.

"BE IT RESOLVED that the HMA Bylaws, section 2.01 be changed as follows:

(Proposed deletion ~~crossed out thus~~)

2.01 Every member in good standing of a component society of this Association shall be a member of this Association, ~~and the American Medical Association~~, either as an active, special, or service member. (no further changes to end of section 2.01).

The motion of substitution was defeated. Resolution 2 was adopted as submitted.

Re: Unity

Whereas, the physicians in this country are being threatened with complete government control of the practice of medicine and Hawaii is no exception, and

Whereas, this objective is clearly identified in PSRO legislation, health manpower legislation, and the National Health Planning and Development Act (PL 93-641), and

Whereas, to divide and conquer is such a simple, fundamental and effective scheme, and

Whereas, unity of county medical society, state medical association, and the American Medical Association is the necessary strong triumvirate to fight governmental control, now therefore be it

Resolved, that this House of Delegates reaffirm its support of unified membership, and be it further

Resolved, that the delegates encourage non-members to join, close ranks in unity for the difficult fight that exists now and in the future for the medical profession.

GEORGE H. MILLS, M.D.

Secretary

ACTION: Filed. The minutes of all Council meetings were ratified as circulated.

The total active membership of the Association as of December 31, 1976 was 1007, an increase of 3 compared to December 31, 1975 which was 1004. The special members numbered 41, an increase of 11 from the previous year. Of the 1007 active members, 126 were granted a dues waiver, an increase of three over the previous year.

Four members died since the last annual meeting: M.L. Chang, Norman Sloan, E.S. Sarvis, and Harry Takenaka.

By counties, the active membership was made up as follows as of December 31, 1976:

COUNTY	ACTIVE DUES— PAYING	ACTIVE DUES— WAIVED	SPECIAL	TOTAL
Honolulu	683	99	40	822
Hawaii	67	16	1	84
Maui	68	6	—	74
Kauai	22	5	—	27
	835	126	41	1007

As of August 31, 1977, the active membership has decreased to a total of 914 members.

Since the last annual meeting, there have been ten Council meetings that were held as follows: January 14, February 4, March 4, April 1, May 6, May 25, July 8, August 5, September 2, and October 21. (The minutes of all Council meetings were attached for ratification by the House of Delegates.)

DOUGLAS B. BELL II, M.D.

President's Report

ACTION: Filed

This has been an interesting and challenging year for Hawaii Medical Association and your leadership. Your Council had monthly meetings the first Friday of each month to conduct its business, while your Commissioners and Committees worked actively throughout the year. Major issues presented by the House of Delegates were met and through the strong support of your Committees & Council, we were able to achieve solutions and answers to many of our problems. Your Commissioners and Committee Chairpersons have detailed this past year's activities in their reports; I would like to highlight the major issues that we tackled and wrestled with during the year.

(1) Malpractice

Malpractice was approached from three different angles: judiciary, legislative, physician utilization and coverage. Act 219, passed by the previous Legislature and signed by the Governor, made malpractice insurance coverage mandatory for licensure. Hawaii Medical Association went to the State Circuit Court to defend the right of a physician to "choose" to purchase malpractice insurance on his own volition rather than as a requirement for licensure. Considerable time, effort, and money was involved in defending the physician's right to practice medicine with or without medical malpractice insurance. Unfortunately, Judge Arthur Fong ruled against the Association and physicians and did not feel that Act 219 infringed upon the individual's right to practice medicine by requiring the purchase of malpractice insurance. Our next step was to approach the Legislature to change the law. An Ad Hoc Committee, chaired by Dr. Len Howard, spent many, many hours with our Legislative lobbyist, Judge Abe, and Legislative Committee to review Act 219 and make the proper changes. The hours spent at meeting and energy expended with Legislators in hearings, caucuses, and personal contacts paid off. We were successful in deleting required insurance for licensure and made other significant changes in the law. Thirdly, an Ad Hoc Committee, chaired by Dr. John Edwards, spent many hours reviewing the feasibility of setting up a self-insurance company, assessing current availability and cost of medical liability insurance, and considering alternatives to insurance for our membership. This Committee did meet with the President of Argonaut Company, the Insurance Commissioner and Director of Regulatory Agencies, other individuals involved in various forms of self-insurance stock company or mal-

practice coverage. We are still attempting to look realistically at what is the best alternative for our membership. This has been a very active committee seeking to define the best risk and low cost value in malpractice insurance.

(2) Continuing Medical Education

In the previous Legislative session, it was mandated by law that all physicians licensed in Hawaii have some form of continuing medical education program as certified by the Board of Medical Examiners. Our Continuing Medical Education Committee, chaired by Dr. Edgar Ho, has worked long hours and regularly over the past year to develop a plan for our membership. This has been formalized and transmitted as our suggestion to the Board of Medical Examiners. Accreditation will be similar to the AMA Physician's Recognition Award and our Association is attempting to maintain records for this membership over the year. This is a State-wide committee and requires coverage for Continuing Medical Education for all our members throughout the State of Hawaii.

(3) Cancer Research Center

A series of meetings began between the Cancer Committee, a Cancer Liaison Committee, and members of the Executive Committee of the Cancer Research Center of the Hawaii Medical Association. This was further broadened to include the members in the American Cancer Society, Hawaii Hospital Association, Department of Health and eventually, the Chancellor and President of the University of Hawaii to clarify the role of the Executive Committee of the Cancer Research Center and the Hawaii Medical Association. President Matsuda of the University clearly stated that the Executive Committee is executive in function and the Director is the manager. The functions and duties of the Executive Committee were reaffirmed and groundbreaking for this Center occurred on August 12, 1977 at Queen's Hospital grounds.

Clarification of the role and control of the Hawaii Tumor Registry was also challenged. This occurred not only in the Legislature but also in various meetings. The Hawaii Tumor Registry is now incorporated under the Hawaii Medical Association and is owned by our Association. We are under a direct grant from the National Cancer Institute through the Cancer Research Center's fiscal agent, the Research Corporation of the University of Hawaii. The Cancer Commission will continue to oversee release of information and the collection of data.

The development of the Community Based Cancer Control Center, through the development of the Cancer Research Center, is the third major area that has taken considerable amount of time and energies of many dedicated physicians of the Association. Education and screening has developed in cervical cancer and will be starting on breast examinations. Rehabilitation and continuing care, research, and training will be other areas that this contract grant will be looking at.

Clinical research and the use of protocol therapy will be actively pursued also under the Cancer Research Center. A Hawaii Oncology Group has been formed and is open to any qualified physician who wishes to participate in protocol cancer therapy.

(4) Emergency Medical Service

We were successful in receiving another grant for the year 1977-1978 of \$784,810 to continue our education and training of paramedics in the emergency medical service on Oahu, expanding this to the rural areas. Dr. Livingston Wong and his staff have been most successful in developing a very strong model of emergency medical service for Oahu. With his retirement in June, 1977, Dr. William Dang has assumed the Directorship of this project. We are continuing to emphasize our expertise in education and training of the paramedics and attempting to work with the Neighboring Islands in establishing their program with the State Department of Health.

(5) Ward Avenue Home

With our move in August, 1976 to our Ward Avenue home,

we have completed our first year in our own building. We have had over 95% occupancy at this time and the building has been self-sufficient. The Hawaii Tumor Registry and PSRO have been situated within the building structure and administratively, it has been of great help. In addition, the various meetings, luncheons and dinners, have brought forth excellent attendance and our home appears well used and becoming for our growing needs. Your leadership has had many meetings with various people including President Matsuda; Director of Health, George Yuen; Director of Social Services, Andrew Chang; Dean of Medical School, Terry Rogers; Dean of Public Health, Jerrold Michaels, and many others at our "home." The availability of meeting rooms has been of tremendous help during various "crisis" that required immediate dialogue and communications with various individuals in a closed meeting.

(6) Department of Health

We have had many meetings with various individuals in the Department of Health. Following the Swine Flu immunization program, we developed a Rubella epidemic that required joint action with the epidemiology division. We have been involved in vision and hearing screening for the school health services; and many other areas of mutual concern.

(7) Department of Social Services and Housing

The concerns of Medicaid cost and abuse brought forth many meetings with Director Chang and Mr. Millard. We have attempted to meet more frequently to discuss approaches to make quality medical care accessible to all Medicaid patients at a usual and customary cost. We are anticipating more open dialogue with the Legislators this coming session.

(8) Health Planning—PL 93-641

The development of State Health Community Councils (SHCC), Subarea Councils (SAC), and State Health Planning Development Agency (SHPDA) for the State of Hawaii instead of the HSA's, etc. has created a strong agency under the Department of Health and the Governor. These groups will be developing annual health plans with implementation recommendations. All medical facilities and care programs will come under the scrutiny of these bodies. It behooves the membership to seek out the consumers and providers that are representing your area or census tract. Your leadership was fortunate to place at least one physician in every SAC but there is a strong need for each member to become aware of the developments in the health plans.

(9) Fee Survey and Relative Value Studies

Committees have been actively pursuing the development of a Relative Value Study; however, with recent Federal Trade Commissions revocation of such studies specifically in anesthesiology and obstetrics and gynecology, we have not published a new RVS schedule. The Federal Trade Commission recently has prevented the Michigan Medical Association from publishing their new study. We are now watching a Bill being submitted in Congress that would amend the Sherman Antitrust Act to permit development and use of relative values studies. A second Bill would amend Title 18 of the Social Security Act to permit HEW to use professionally prepared relative value studies to determine reasonable charges to physician service.

(10) American Medical Association

We were very fortunate to see our Delegate George Mills get elected to the Board of Trustees of the AMA in the June, 1977 San Francisco meeting. Dr. Mills's presence on the Board should give us greater insight and voice on the AMA affairs. We are indeed unique when you consider that our one delegate was elected on the 12-member Board with over 279 voting members of the House of Delegates!

(11) Leadership Conference

A successful leadership conference was held on October 2, 1977 with good attendance from the neighboring islands and Oahu. Missions and goals were discussed and the focus

of the group centered on strengthening membership and improving methods of representing the medical profession. Many excellent ideas and concepts were generated and hopefully some of these can be pursued in the coming year.

(12) Communications

Many meetings have been held with various community agencies and departments of government in an attempt to promote a better understanding and open communications between the HMA and other agencies. The officers and key committee members have held meetings with the hospital chiefs-of-staff, specialty societies, the Department of Health, Department of Social Services, School of Medicine, School of Public Health, community college representatives, Department of Regulatory Agencies, etc. We were also pleased to receive visitors from Hiroshima on two occasions, and we plan to visit Hiroshima in November to officially sign our resolution of a sister association with the Hiroshima Prefectural Medical Association. It is important that HMA continue to communicate with the community and governmental agencies, as well as with other segments of the health community.

There are many other areas that have been touched upon in the various chairmen's reports: death and dying, negotiations, Mabel Smyth, child health plan, etc. I would like to conclude by stating that it has been a real pleasure to have served as your leader this past year, especially with the dedicated staff that has so ably assisted me and the strong support of the various Councilors, Commissioners, Chairpersons, and members of the Association. We must continue to open up communications between leadership and grassroots and support organized medicine. We need your continued *kokua*. Mahalo!

Recommendations:

- (1) Improve communications with membership.
- (2) Pursue alternatives to malpractice insurance.
- (3) Seek out methods for financing EMS program when federal grant is completed.
- (4) Continue dialogue with various leadership in the community on health matters.

CALVIN C. J. SIA, M.D.

Commission on Internal Affairs

ACTION: Approved with amendments.

The Commission on Internal Affairs consists of four committees: Bylaws, Arrangements, Scientific Program, and Publications. The reports of these committees are reprinted below and the Commission recommends adoption of the recommendations of the committees:

DOUGLAS B. BELL II, M.D., *Commissioner*

Bylaws Committee

The Bylaws Committee met on two occasions to review the bylaws in accordance with the requirements of Chapter 12 which require a review every five years. A memorandum to the membership containing the substance of the proposed changes to the bylaws was sent on August 30.

Amendments to HMA Bylaws (as adopted)

(1) *Resolved*, that the Bylaws of Hawaii Medical Association, as amended, shall be further amended by adding to Bylaw numbered 2.10 new subsections numbered and reading as follows:

"2.106. Upon a request by the Board of Governors of any component medical society chartered by Hawaii Medical Association to do so with reference to any charge or complaint made against any member of the requesting component society, the Council of the Association shall designate a committee of the Association to act in the place and stead of such committee, board, or commission of the requesting component society as shall, pursuant to the Bylaws of such component society,

have the power and duty to investigate charges or complaints against any member of such component society, and the power, duty and authority to take or recommend disciplinary action by such component society against the members of such component society.

"2.107. Any committee designated to act in the place and stead of a committee, board or commission of a component society pursuant to 2.106 above, shall carry out the duties of the committee, board or commission of the component society for which it is a substitute, in accordance with the Bylaws of such component society.

"2.108. The provisions of Sections 2.101 through 2.105 of the Bylaws of Hawaii Medical Association shall be applicable following any action taken by any committee designated pursuant to 2.106 above; PROVIDED, HOWEVER, that no member of the Council of the Association who was a member of a committee of the Association designated pursuant to 2.106 shall participate in the deliberations or decisions of the Council in its exercise of appellate jurisdiction relating to any matter with reference to which such Council member also acted as a committee member."

(2) *Resolved*, that the Bylaws of HAWAII MEDICAL ASSOCIATION, as amended, shall be further amended by adding to Bylaw numbered 5.015 a new sentence reading as follows:

"Any member of Hawaii Medical Association who is an elected officer of or a member of the Board of Directors of American Medical Association, and all past presidents of Hawaii Medical Association who are members of Hawaii Medical Association in good standing, shall be *ex officio* members of the Council of Hawaii Medical Association; *provided, however*, said *ex officio* members shall not be counted in determining the whole number of members of the Council for the purpose of determining the number of members of the Council required to be present to constitute a quorum as called for under 5.05."

(3) *Resolved*, that the Bylaws of HAWAII MEDICAL ASSOCIATION, as amended, shall be further amended by adding to Bylaw numbered 4.011 a new sentence reading as follows:

"Any member of Hawaii Medical Association who is an elected officer of or a member of the Board of Directors of American Medical Association, shall be an *ex officio* member of the House of Delegates of Hawaii Medical Association; *provided, however*, said *ex officio* member, and all living past presidents of the Association who are also members of the House of Delegates of the Association, shall not be counted in determining the whole number of members of the House of Delegates for the purpose of determining the number of members of the House of Delegates required to be present to constitute a quorum as called for under 4.061."

(4) *Resolved*, that the Bylaws of HAWAII MEDICAL ASSOCIATION, as amended, shall be further amended by amending Bylaws numbered 9.031 and 9.032 to read as follows: (New material is underlined, and to be deleted material is in []). The underlining and the brackets, and the material in brackets shall be omitted from the bylaw when amended.)

"9.031 A member is delinquent if his dues for any year are not received by the Association by April 1 of that year and shall automatically forfeit his membership in the Association if he fails to pay the delinquent dues within 30 days after the notice of delinquency has been certified mailed by the Secretary of the Association to his last known address, and to the Secretary of the county medical society to which the delinquent member belongs. The same penalties shall apply to a failure to pay assessments, or to pay special funds, the collection of which from members has been provided for by the Council. Delinquency that begins [beginning] 90 days after the levying of the assessment, or the giving of notice by the Council that special funds are to be paid, and forfeiture of membership for nonpayment shall occur[ring] automatically 30 days after the mailing of

notification of delinquency to the member and to the Secretary of his county medical society.

"9.032 Members of the Hawaii Medical Association who have been dropped from the membership roll for nonpayment of annual dues or assessments or special fund can [cannot] be reinstated [until such indebtedness has been discharged, but such indebtedness shall apply only to the one year of delinquency.] upon payment of all dues, assessments, and special funds payable in the year of reinstatement. Reinstatement of delinquent members shall be automatic with the full payment of the member's indebtedness."

(5) *Resolved*, that the Bylaws of HAWAII MEDICAL ASSOCIATION, as amended, shall be further amended by amending Bylaw numbered 4.041 to read as follows: (New material is underlined, and to be deleted material is in []). The underlining and the brackets, and the material in brackets shall be omitted from the bylaw when amended.)

"4.041 In each year there shall be one regular session of the House of Delegates, which shall be held [in April or May unless otherwise determined by the Council.] at such time each year as shall have been determined by the Council, and this session shall be designated as the annual session."

(6) *Resolved*, that the Bylaws of HAWAII MEDICAL ASSOCIATION, as amended, shall be further amended by amending Bylaw numbered 12.01 to read as follows: (New material is underlined, and to be deleted material is in []). The underlining and the brackets, and the material in brackets shall be omitted from the bylaw when amended.)

"12.01 [These bylaws shall be reviewed in detail at least every five years.] These Bylaws shall be reviewed annually by the officers of the Association and their recommendations for amendments shall be submitted to the Bylaws Committee of the Association not less than 90 days prior to meeting of the House of Delegates or the duly called meeting of the Association at which a vote on the adoption of the recommended amendments is to be taken. They may be amended at any meeting of the House of Delegates or at a duly called membership meeting of the Association by a two-thirds (2/3) vote of the members present and voting, provided that notice of the substance of any proposed amendment shall be mailed to each member of the Association and to the president of each component society at least sixty days prior to the date of the meeting at which the vote is taken, provided further that after such notice, changes in such proposed amendments may be adopted at a meeting without further notice to the members."

(7) *Resolved*, that the Bylaws of HAWAII MEDICAL ASSOCIATION, as amended, shall be further amended by amending Bylaw numbered 9.011 to read as follows: (New material underlined, and such underlining is to be omitted from the bylaw when amended.)

"9.011 The annual dues of the Association and the fee for the support of the HAWAII MEDICAL JOURNAL shall be recommended to the Council of the Association at its final meeting prior to the annual session and shall be subject to ratification or amendment by the House of Delegates of the Association. The Council (with the exception of 9.041 and 9.042) with the approval of, or acting under prior authorization by, the House of Delegates, may levy special assessments, or may provide for the collection from the members of the Association of special funds. Each member shall pay the prescribed annual dues and all assessments to his component society for transmittal to this Association. All monies collected by each component society for transmittal to the Hawaii Medical Association shall be transmitted at least monthly."

(8) *Resolved*, that the Bylaws of HAWAII MEDICAL ASSOCIATION, as amended, shall be further amended by amending Bylaw numbered 9.05 to read as follows: (New material is underlined, and to be deleted material is in []). The underlining and the brackets, and the material in brackets shall be omitted from the bylaw when amended.)

"9.05 *Special Funds*. Funds may also be raised by voluntary contributions, from the Association's publications, [and] or in any other manner approved by the House of Delegates."

(9) *Resolved*, that the Bylaws of HAWAII MEDICAL ASSOCIATION, as amended, shall be further amended by amending Bylaws numbered 8.011 and 8.10 to read as follows: (New material is underlined, and to be deleted material is in []). The underlining and the brackets, and the material in brackets shall be omitted from the bylaw when amended.)

"8.011 Commissions and committees may be created by the President, the Council, or the House of Delegates as they deem necessary. The Chairman of any Committee assigned to a Commission shall make an annual report to the Commissioner who shall include such reports, or the substance thereof, and all recommendations and budget requests therein in his report to the House of Delegates. The Chairman of any Committee not assigned to a Commission shall make an annual report to the constituting authority."

"8.10 *Standing Committees*. All permanent appointive committees of the Association shall be known as standing committees. They shall serve upon request in an advisory capacity to the State Health Department or any other agency or person, when called to do so by the President or the House of Delegates. [The chairmen of the standing and special committees shall make annual reports to the House of Delegates of the Hawaii Medical Association.] If a committee desires a budget to carry on its functions, such request shall be incorporated into the committee's annual report. Interim requests for funds may be directed to the Council."

Recommendation: The Committee recommends that the changes in the bylaws be adopted as outlined above.

DOUGLAS BELL, II, M.D., *Acting Chairman*
for HARRY ARNOLD, JR., M.D., *Chairman*

Arrangements Committee

This Committee met several times during the year to coordinate the activities of the 121st Annual Meeting of the HMA, held this year in conjunction with the AMA Regional Meeting. The Sheraton-Waikiki Hotel was selected as the convention site, anticipating an increased attendance and requiring a greater number of meeting rooms for the combined meeting.

The AMA was responsible for postgraduate course arrangements, AMA daily breakfasts, and pre-registration. HMA was responsible for its own annual meeting which include the plenary and State-of-the-Art lectures, exhibits, House of Delegates meeting, sports tournaments, banquet, and on-site registration. This year, for the first time because of the joint meeting, the HMA hosted the Sunday evening cocktail reception to welcome mainland registrants.

Although this was a joint effort, HMA's annual meeting for the most part was similarly patterned after previous meetings. Instead of the usual four mornings of scientific meetings, it was extended to five mornings this year. Sports tournaments were planned to conclude before the Sportsmen's Party. Forty-one booths were set up for exhibits in a room adjoining HMA's lectures. The House of Delegates meetings were scheduled on two consecutive days. The annual banquet, as usual, culminates the meeting where awards presentations and installation of officers are part of the program.

Pre-registration for the combined meeting created some confusion. All AMA postgraduate course registrants were required to pre-register and pay the course fee to AMA. Non-HMA physicians were charged a registration fee of \$25 and an additional \$15 fee was charged to non-AMA physicians. Those desiring to attend only the HMA plenary and state-of-the-art lectures were allowed to register directly with HMA, and for these sessions non-HMA physicians were charged a \$25 fee.

The AMA Committee on Continuing Education Seminars has expressed their hopes of continuing this joint meeting. Should the HMA decide to continue with AMA, and, depend-

ing on this year's attendance, AMA would be willing to decrease the number of postgraduate courses and/or shorten the number of days of the next meeting. Toward this end, pending the decision of the 1977 HMA House of Delegates, tentative reservations have been made at several Honolulu hotels. There has been increasing interest in holding this 1978 meeting in Maui as the President-elect is from Maui. This interest in going to Maui in 1978 is shared by AMA.

Recommendations:

- (1) That HMA plan on having another joint meeting with the AMA for 1978.
- (2) That the 1977 Arrangements Committee be allowed to study and to make definitive plans for time and location of the 1978 meeting with approval from the Council.

DOUGLAS B. BELL, II, M.D., *Chairman*

Scientific Program Committee

The purpose of this committee is to plan and implement an educational program in conjunction with the annual meeting of the Hawaii Medical Association.

Because of the complexities of this year's innovative joint meeting with the AMA Regional Continuing Education Program, the committee began planning for this in August of 1976. The then chairman for this committee, Dr. John Watson, met at periodic intervals to develop a plan, and it was decided to have a format in which the AMA would be responsible for the Category I postgraduate courses and that the HMA would be responsible for the State-of-the-Art lectures and the plenary sessions as well as for the scientific and commercial exhibits. The HMA was also made responsible for the selection of the topics and for the faculty of the postgraduate courses, with the understanding that as much as possible, in the sake of economy, we would attempt to use faculty from within the State of Hawaii with occasional additional faculty from the mainland. The number of courses was set at approximately 12 with repeats of 3 or 4 of the more popular courses. Our early estimate was to expect approximately 600 physicians to attend the meetings. With the departure of Dr. Watson in April, I was asked to chair the committee and proceed with implementing the plans.

Our original intentions was that we would continue our policy of charging approximately \$50 - \$100 for the mainland physicians to attend the Hawaii Medical Association meetings. However, because of the larger number expected this year, the committee decided that a reduced fee of \$25 would be adequate, although there was still some objection to this fee by the AMA. In June of 1977, in order to firm up some future plans for this year, Mrs. Bess Chang and I attended the AMA meeting in San Francisco and met with Mr. Gail Jewett and Dr. Sherveth Frazier, Jr., chairman of the Committee on Continuing Education Seminars of the AMA. During this meeting, initial discussion was held on the possibilities of continuing the relationship of the Hawaii Medical Association with the AMA postgraduate courses for the future.

In summary, this year's Scientific Program of the Hawaii Medical Association will be a joint effort with the AMA Committee on Continuing Education Seminars.

For next year, it is hoped that this relationship will continue, and depending on the outcome of this year's program, necessary changes are to be made either in expansion or reduction of the number of the programs. We hope that the membership will make their wishes known at the time of the annual meeting.

HERBERT S. UEMURA, M.D., *Chairman*

Publications Committee

During 1977 the Publications Committee guided the monthly publication of the HAWAII MEDICAL JOURNAL. Letters of solicitation were sent to all non-dues paying members as well as non-members of HMA and yielded 34 additional subscriptions to the Journal. A similar mailing to all upper

classmen at the University of Hawaii School of Medicine yielded no response.

Efforts are continuing to establish liaison with the Hawaii Pharmaceutical Association and the Hawaii Chapter of AMSA. The HMJ remains solvent and the source for medical community news as well as scientific articles of local interest.

In January 1977 a three-year contract was signed with Elson-Alexandre to print the Roster on an annual basis.

Recommendations:

- (1) Continue monthly publication of the Journal.
- (2) Appointment of Harry L. Arnold, Jr., M.D. as Editor of the HMJ for 1978.
- (3) That a budget of \$3,000 be allocated for publication of the 1978 edition of the Roster.

WILLIAM F. MOORE, JR., M.D., *Chairman*

Ad Hoc Committee on Death and Dying

This committee met on July 21 and August 10, 1977 at the request of the HMA President. The major consideration concerned how the HMA should testify regarding House Bill 258, relating to the definition of death. In official testimony and in cross-examination based on the recommendation of the Ad Hoc Committee, Dr. Raymond Taniguchi and the chairman testified to the following position:

1) We prefer that the term "consultant physician" be used instead of a "neurologist", "neurosurgeon", "anesthesiologist" or "internist."

2) If the consulting physician was going to be defined in terms of specialty, then it would be better to use the four specialties above rather than "neurologist" and "neurosurgeon" alone.

3) Rather than to defeat this legislation, it would be better to include only neurologists and neurosurgeons. It should be pointed out that the bill, as written, refers to irreversible cessation of brain function and does not make any specific reference to the Harvard criteria of death, which would require a neurologist or neurosurgeon.

In stipulating specialties, a special problem is created for the pediatricians in the Pulmonary Unit at Children's Hospital, where a respirator may be withdrawn in the case of irreversible pulmonary failure.

Recommendations:

- (1) The Committee would like to recommend that its Ad Hoc status be continued and its title changed to "Emerging Medical, Moral and Legal Concerns." This type of committee could continue to evaluate multiple issues which are coming about in contemporary society of which death and dying is only one aspect. The new technologies of respiratory care, artificial kidney machines, transplantation of various organs and probable artificial hearts have created many unusual problems. How well we meet these problems might well determine how much patient confidence remains for physicians.
- (2) The Committee would like to suggest that this Committee consider establishment of a Counseling Committee which is described as follows:

Counseling Committee:

Broadly representative of medical, legal and moral sensitivities as well as other values. Have counseling skills represented (Psychiatry, social worker, theology, etc.). Have legislature represented.

Confidentiality:

Must have approval of patient or guardian.

Purpose:

Resource panel for patient, guardian, physician or court.

- a) Has prognosis been evaluated by appropriate medical consultation?
- b) Have all alternative solutions been considered?
- c) Is final decision reasonable?

Operation:

- a) Decision made in traditional way between patient and doctor *or* guardian and doctor.
 - b) No final authority (only court could override guardian decision).
 - c) Patient should bring his family, friends, lawyer, clergyman, etc.
 - d) Gather data as to ordinary practice (usual or customary?).
- (3) That HMA provide this committee with secretarial help and meeting space to support this committee during the coming year.

It is felt that this committee should reside somewhere on a statewide level. Whether it belongs within HMA, which is what is preferred, or outside, must be debated. It should be considered that it would be quite expensive to maintain this within the HMA structure.

ARNOLD W. SIEMSEN, M.D., *Chairman*

Bureau of Research and Planning

ACTION: Approved and that a sum of \$5,000 be provided in contingent funds in the budget to supply seed money for this project or others of a similar nature which may develop in the next twelve months.

Several meetings were held and a grant proposal for diabetes will be developed. This grant would fund 1) basic research and development of demographic information in conjunction with the University of Hawaii John A. Burns School of Medicine, and 2) an educational program spearheaded by the HMA focusing on community out-reach and physician education.

One other project may be developed but this is subject to Federal regulations.

I would like to thank the members of the committee for participating during the discussions.

HERBERT Y.H. CHINN, M.D., *Chairman*

Medicaid

ACTION: Approved

After the passage of the 1976 bill in the State Legislature which adjusted the physicians payment from the usual and customary to the 75th percentile, HMA spoke against a house bill which would have made payments 50% of the usual and customary in the 1977 Legislative session. There was an administrative bill introduced in the Senate during the 1976 session on which no hearing was held, but it will most likely be activated in the 1978 Legislative session. This bill, if passed, will go back to the payments prior to 1976. Meetings have been held with DSSH's Director on the concerns that HMA has on the rise of medical costs and means to control the abuses of the program. Funds have been allocated to the DSSH for 1977 to have an additional position for controls of abuses in the program.

Recommendations:

- (1) HMA continue to keep the Legislators informed of the need for the usual and customary up to the 75th percentile.
- (2) HMA continue to work with DSSH on the problems relating to Medicaid.

ROY KUBOYAMA, M.D.

Executive Director's Report

ACTION: Filed with recommendation that Mr. Won be commended for his diligent efforts on behalf of the HMA during his first year as Executive Director.

I have just concluded my first year as your Executive Director, and my first comments must be to express gratitude of the deepest kind to the HMA leadership and to the HMA staff, for their support and dedication has not only made my task easier but highly worthwhile!

The problems faced by the Association were not necessarily unknown to me as I assumed the senior administrative position, but the pace of the action has increased so rapidly, along with other developing problems, that it was necessary to realign the staffing patterns in order to meet the ever-growing needs of the physician membership and the organizational operations. Three long-time members of the staff were promoted to junior executive positions and have performed extremely well. Reassignment of responsibilities and better documentation of activities have all produced a staff that is able to respond to your organization's needs.

Your President's Report contains all of the issues and concerns dealt with over the past year. Perhaps it would be worthy to note some concerns that will continue into the next year. The HMA building needs to be looked at, not from the standpoint that it is in any trouble, but from that of how to make the building, now fully occupied, work to the best advantage of the Association. Re-financing is being looked into as one possible mechanism. This is a fine home for the Association and the leadership should be commended for its decision to acquire this building.

Malpractice insurance, and alternatives to what is available to physicians today, must continually be monitored, for the problems created in the past are not completely over. While the "crises" that existed some years ago has leveled off, a firmer approach to malpractice insurance must be realized if the cost, eventually to your patients, is to be kept within reasonable bounds.

The HMA-Emergency Medical Services Program is one that physicians and this community can be proud of, for it has evolved into a nationally-recognized program. The future of this program is now in its investigative stages regarding its funding, and all physicians need to be aware of the program's progress.

The new "health planning law," Public Law 93-641, is perhaps the most far-reaching of any piece of health legislation in the past century. Generally, physicians do not realize the great impact this law, and the activities it generates, will have on one's medical practice. It is definitely not a good law, as I see it, for physicians, patients, and the community. But law it is, and it is up to physicians to become involved at the community level to see that the law is implemented in the best interest of patients.

The organization and its committees, commissions, and bureaus have worked this past year. During the past 12 months, some 549 meetings have been scheduled in your new Association home alone. I commend each and every physician who has found it within himself or herself to give to the Association and to the medical profession in the interests of patient care. I hope each and every one of you physicians continue to participate in and support your Association, for it has been clearly demonstrated that good things can be accomplished.

For those physicians who are members and have not yet had the opportunity to actively participate in the Association, please let your leadership know that you are interested and the specific areas of interest, for your Association needs you, and there is much that can be done together.

I sincerely hope that you are as proud of being a member of HMA as I am proud to be able to provide support for the Association activities, for there is much to be proud of. Let's keep it that way!

JON R. WON

Resolution No. 4

ACTION: Adopted as amended

Re: Treatment of Eye Disease/Injury

Whereas, the practice of Medicine includes the use of drugs and medicines, and other modalities or agents, either tangible

or intangible, for the treatment of disease in the human subject, and

Whereas, the use of eye drops to dilate the pupil for the diagnosis or the treatment of disease, (steroids, antibiotics, cycloplegics or mydriatics, etc.) constitutes the practice of medicine, and

Whereas, the use of such agents or other medical agents by persons not licensed to practice medicine, violates and is contrary to the definition of the legal practice of medicine, and

Whereas, allowing such practice by those who have not been trained in the basic disciplines of medicine, and are without proper education of the eye in relation to the bodily systems, including physiology, anatomy, neuro-anatomy, pharmacology, toxicology, and drug interactions, as well as the complications of systemic disease and their effect on the eye, could endanger the health and welfare of the citizens of this State, and

Whereas, the protection of the health and welfare of the citizenry is one of the primary purposes of legislation in all fields pertaining to said citizens, now therefore be it

Resolved, that the Hawaii Medical Association reaffirm its policy that only physicians trained and licensed to practice Medicine and Surgery, in all its branches, are qualified to prescribe or apply eye medications, and be it further

Resolved, that the Hawaii Medical Association opposes legislation authorizing individuals not licensed to practice Medicine and Surgery to prescribe or apply eye medications in the diagnosis, or treatment of disease or injury of the eye except under supervision of a licensed physician.

O. D. PINKERTON, M.D.

Reference Committee on Finance and Peer Review

Hawaii Medical Journal

ACTION: Approved

The entire staff associated with the Journal is to be congratulated for not only meeting the challenge of a monthly publication date, but doing it in a professional and businesslike manner.

As mandated by the House of Delegates, the Publications Committee continued to meet regularly with the Journal editors during the year to closely monitor the expenses, income, and direction of the Journal. Typically, during 1977, the Journal consisted of a 37 page magazine. Of this, 8 pages would be scientific articles, 14 pages editorial of some nature and 15 pages, or 40.5% of a typical issue, advertising.

It was determined that a ratio of 40% advertising to 60% editorial would be the optimum formula the Journal would have to follow. Maintaining this ratio has been difficult in light of the fact that we once again find ourselves with a year's supply of scientific articles to be published. To work down this supply, we must generate additional advertisers. We urge all members to keep this in mind when the detail men come to call.

Regular contributors to the Journal include: Doris Jasinski, who continued to edit all manuscripts; Fred Reppun for his Editorials and Family Physicians Newsletter; Henry Yokoyama for the controversial News and Notes; Francis Fukunaga for Clinical Pathologists Easy Chair; Jon Won for the HMA Newsletter and Paul Steward for fitting all the pieces together.

Recommendation:

- (1) That the House of Delegates give the Publications Committee permission to authorize advertising rate increases to be effective January, 1978.
- (2) That the Publications Committee continue to pursue the possibility of increasing the number of scientific articles in each issue.

J. I. F. REPPUN, M.D.
for HARRY L. ARNOLD, JR., M.D.

Commission on Peer Review

ACTION: Approved

The Peer Review Commission consists of the Peer Review Committee, the Maternal and Perinatal Mortality Study Committee, and the Professional Liability Committee.

The Peer Review Committee held no formal meeting during this past year.

The Maternal and Perinatal Mortality Study Committee has met regularly to discuss and review all maternal and selected perinatal deaths on a statewide basis. This is a very active and hard-working committee which reviewed a total of 40 maternal and perinatal deaths this past year.

The Professional Liability Committee met twice this year. Work load of the Committee has dropped to minimal levels since the mechanism of the professional liability law relevant to the conciliation panel hearings were started.

Recommendation:

- (1) That each County Medical Society review its by-laws concerning peer review with legal counsel, and be sure that due process is being followed in all such deliberations.
- (2) That the House of Delegates encourage family practitioners who do obstetrics and pediatrics to become members of the Maternal/Perinatal Study Committee.

ANN B. CARTS, M.D.

Commission on Interprofessional and Public Affairs

ACTION: Approved as amended

The Commission on Interprofessional and Public Affairs consists of the following: Health Facilities Committee, Interprofessional Relations Committee, Intraprofessional Liaison Committee, Public Affairs Committee, and TV-Radio Committee.

Health Facilities

The Health Facilities Committee did not meet in 1976-77. However, some items have come in that do need attention and hopefully this committee will become active during the coming year.

Interprofessional Relations or Medical/Legal Committee

This important committee has not met during this past year.

Intraprofessional Liaison Committee

This committee met twice and discussed such issues as: Malpractice, DSSH Medicaid, Self-Insurance, PL 93-641, CME, EMS, Cancer, and the use of HMA's staff and facilities for specialty societies. No actions were taken.

Public Affairs Committee

The committee met several times during the year. They continued the relationship with the Hawaii News Agency in presenting Public Forums on Lung Diseases, and Keeping in Shape-Recreational Health Hazards. This spring included the pleasant task of judging exhibits at the Science and Engineering Fair. The committee has recently come under the direction of a new and vigorous chairman. The most recent actions taken were: the selection of Dr. Harry Arnold, Jr. as Physician of the Year-Robins Award; Ms. Tomi Knaefler of the Honolulu Star-Bulletin for the HMA Journalism Award; and special recognitions to be awarded at the Annual Banquet to KGMB-TV, Oceanic Cablevision and to the Honolulu Star-Bulletin for its innovation of The Health Page. Items the committee will pursue will include recommendations or revisions for the Yellow Page listings in the phone directory, the Publicity Code, and in particular, new ideas for the Public Forums because of decreasing audiences.

Tel-Med has gained considerable strength with phone calls per day averaging between 400-500 and has added a number of new tapes to the library, and to soon add on a trial basis, a selected few tapes translated into Ilocano, Filipino, Japanese, Chinese, and Samoan. Plans are moving along well for its expansion to the other islands via direct phone lines. The

Tel-Med Joint Executive Committee consisting of two representatives from HMSA and two from HMA has met on at least a quarterly basis. A well-developed promotional schedule has been outlined for the coming months.

TV-Radio Committee

The TV-Radio Committee has met monthly and continues very active. The weekly health information programs, taped by Punahou School Instructional TV without charge are aired on Channel 10, Oceanic Cablevision. The tapes used will be kept at the Hawaii Medical Library for future use. MEDIX continues to have very favorable public response. The Japanese Speakers Bureau remains active weekly. Further TV-Radio health outlets are being developed.

The budget request is for \$3,000 and includes especially the cost of TV tapes. Approval is recommended.

Recommendation:

- (1) That the budget requests for the Public Affairs and TV-Radio Committees be approved.
- (2) That the HMA Council actively investigate the possibility of obtaining the services of a Public Relations person.
- (3) That the Health Facilities Committee and the Intraprofessional Committee be terminated.
- (4) That the Interprofessional Committee be revitalized with Co-chairmen, one representative from the Bar Association, and the other from HMA.

Budget Request

News Media Awards	\$ 800.00
Science Fair	200.00
Tel-Med	6,000.00
Miscellaneous	50.00
TV-Radio	3,000.00
Total	\$10,050.00

ROWLEN LICHTER, M.D.

Commission on Medical Services

ACTION: Approved with the recommendation that the request for publishing a new edition of the RVS be budgeted but that it be subject to release at the discretion of the Council.

The Commission on Medical Services consists of three committee: Economic Evaluation and Adjustment Committee, Fee Survey Committee, and Worker's Compensation Committee. The reports of these committees are reprinted below:

WILLIAM F. MOORE, JR., M.D., Commissioner

Economic Evaluation and Adjustment Committee

The Economic Evaluation and Adjustment Committee met on one occasion in the past year with the Veterans Administration to negotiate a revised fee schedule. It was agreed that our request will be submitted to Washington for approval. We are presently awaiting word from VA on their final decision. We do not have any budget request.

CHEW MUNG LUM, M.D.

Fee Survey Committee

The Fee Survey Committee has been working very hard at establishing a new Relative Value Studies. The new RVS will be much larger than the previous one and much more detailed. There have been considerable problems in getting this ready for print. However, progress is being made and hopefully this new book will be issued by the end of the year or the first of 1978.

1978 will require a lot of work by this Committee in interpreting the new RVS, in handling inquiries and complaints from insurance carriers.

The budget request for 1978 is \$20,000 to meet the cost of publishing a new edition of the RVS.

MAURICE W. NICHOLSON, M.D.

Worker’s Compensation Committee

The Worker’s Compensation Committee met on one occasion this year to discuss a proposed change in the Worker’s Compensation Law which would allow the payment for medical services rendered to injured workers to be paid on a usual, customary, and reasonable basis. The bill was not reported out of committee, and it is recommended that the committee again attempt to enact this type of legislation in 1978.

The chairman of the committee was asked to participate as a panelist with a representative from the insurance industry and a representative from the Department of Labor before an audience of medical assistants, insurance claims processors, and others who use the Worker’s Compensation Medical Fee Schedule. Those who recommended changes in the fee schedule were encouraged to participate in the public hearings on the medical fee schedule which are scheduled for mid-November 1977.

At the public hearings, it is planned to again request that the Department of Labor adopt the Relative Value Studies in lieu of a fixed fee schedule which must be revised annually. It will also be more efficient for physicians as well as insurance carriers to follow the various codes and descriptors with which they are already familiar.

Budget Request: Some legal assistance may be necessary to prepare for the public hearings in November.

BERNARD M. SCHERMAN, M.D.

1978 Budget

ACTION: The Reference Committee presented their recommendations for the 1978 budget (shown in Column 4 of the 1978 budget). A motion was made and seconded to include the monies requested for the EMS project in estab-

lished line items rather than as a single total. It was voted to include \$1,200 for MICT Graduation in the Council Contingency Fund, \$40,000 as a Special Council Contingency Fund (EMS) and \$10,000 as Legal Expense. A second motion was made, seconded, and approved to reduce the \$10,000 for EMS Legal Expense to \$6,000. It was also moved, seconded, and approved that all budget item expenditures for 1978 be subject to the approval of the Council with the understanding that the HMA Executive Committee can act for the Council in emergency situations.

Treasurer and Finance Committee

ACTION: Approved with the recommendations (1) that a membership dues increase of \$25 for 1978 be instituted; (2) that serious consideration be given to yearly increments in the dues to more clearly reflect the expenses of the organization; and that the Treasurer and Finance Committee make a specific recommendation as to the dues each year; (3) that the Council be authorized to actively investigate methods of refinancing the 320 Ward Avenue property, to effect such refinancing should a favorable mechanism be discovered, and that they keep in mind the previously stated desire of the House of Delegates that repayment of member contributions to the capital fund be made as soon as feasible.

It appears that the projections for the 1977 budget will show some loss in membership income. It also seems that the HAWAII MEDICAL JOURNAL will hold its own. There will be increased income from PSRO as there is increasing activity in this area. The expenditures for the year seem in line; however, it should be noted that the salary expense item is much higher than last year. This, however, is due to the increase in the number of persons working for the PSRO and PAC PSRO staff are all HMA employees. The PSRO program will be reimbursing HMA for these costs.

Ninety-six percent of those eligible have already contributed to the Building Fund as of September 30, 1977. We believe the participation is good and will allow the fund to do its job. The building financial statements are encouraging and the cash flow is improving because for all practical purposes, the building is fully occupied.

Now that the building is completely occupied, we will begin to see a more accurate picture of its financial capability. Our

Hawaii Medical Association
Budget for 1978

	Estimated Annual 1977	1977 Budget	1978* Budget	Reference Committee Recommended Budget	House of Delegates Approved 1978 Budget
INCOME					
Members Dues	167,000	185,000	180,000	170,000	189,750
Journal	60,000	59,000	65,000	60,000	60,000
Annual Meeting	32,000	67,000	32,000	24,500	24,500
Roster	150	1,500	1,500	1,500	1,500
Indirect Cost—EMS	120,000	-0-	-0-	-0-	-0-
Indirect Cost—HTR	25,000	-0-	-0-	-0-	-0-
Indirect Cost—Other	-0-	-0-	-0-	-0-	-0-
Interest Earned	2,500	3,500	3,500	3,500	3,500
Miscellaneous	100	100	100	100	100
Dues Collection Service	1,100	2,000	1,500	1,500	1,500
PSRO—Salary and Fringes Reimb.	111,000	111,000	244,900	234,900	234,900
PSRO—Services	41,000	13,000	47,000	55,500	55,500
Fee Survey	500	5,000	5,000	5,000	5,000
Continuing Medical Education	750	1,000	1,000	1,000	1,000
Printing and Xerox	4,500	4,500	4,500	4,500	4,500
Contract Services—HCMS	75,600	75,600	70,000	72,500	72,500
Other Reimburse Revenues	1,200	-0-	1,200	1,200	1,200
Travel Reimb.—HTR	-0-	-0-	8,000	8,000	8,000
PSRO Reimb.—Meeting Expense	-0-	not budgeted item 1977	5,000	5,000	5,000
TOTAL	642,400	528,200	670,200	648,700	668,450

Hawaii Medical Association Budget for 1978

EXPENSES	Estimated Annual 1977	1977 Budget	1978* Budget	Reference Committee Recommended Budget	House of Delegates Approved 1978 Budget
Salaries	246,000	246,000	376,000	376,000	376,000
Actuary	3,000	3,000	2,000	2,000	2,000
Auditing	4,500	5,000	4,500	4,500	4,500
Auto Expenses	6,500	4,000	6,500	6,500	6,500
Computer Reports	400	300	450	450	450
Council Expenses	4,000	4,000	4,500	4,500	4,500
Donation	100	100	100	1,000	1,000
Dues & Subscription	800	750	800	800	800
HAMPAC—Political Educ. Fund	750	500	1,000	1,000	1,000
Insurance & Bond	7,500	3,000	7,500	7,500	7,500
Lease Rent—Office Equipment	4,200	4,200	4,200	4,200	4,200
Library Contribution	5,000	5,000	5,000	5,000	5,000
Legal & Professional	7,000	3,000	4,000	4,000	10,000
Meeting Expenses	15,000	10,000	15,000	15,000	15,000
Postage	4,000	5,200	5,200	5,200	5,200
President's Assistant	6,000	12,000	12,000	12,000	12,000
President's Contingency Fund	800	1,000	1,000	1,000	1,000
Subsidy for Space	29,000	-0-	29,000	-0-	-0-
Repairs & Maintenance	6,000	1,200	3,000	2,000	2,000
Retirement Contribution	36,000	35,000	42,000	42,000	42,000
Stationery, Printing & Supplies	18,000	8,000	20,000	20,000	20,000
Taxes (FICA, FUTA, W/C)	21,000	12,500	20,000	20,000	20,000
Telephone	3,600	5,000	5,000	5,000	5,000
Travel	13,000	13,200	15,000	13,500	13,500
Auxiliary	9,000	11,000	10,000	10,000	10,000
Committee Expenses	17,000	17,450	17,500	20,810	20,810
Journal	48,000	52,000	50,000	50,000	50,000
Annual Meeting	24,000	24,000	24,000	24,000	24,000
Roster	-0-	3,000	3,000	3,000	3,000
Continuing Medical Education	12,000	12,000	12,000	12,000	12,000
Fee Survey	-0-	20,000	20,000	20,000	20,000
Depreciation	1,000	1,000	-0-	-0-	-0-
Special Authorized Expense—HTR	9,500	10,000	10,000	8,000	8,000
Council Contingency	30,000	50,000	15,000	15,000	16,200
Education & Training	-0-	not included in 1977 Budget	4,000†	3,000	3,000
Miscellaneous	400	500	500	500	500
Interest—Equipment Loan	1,400	-0-	1,400	1,400	1,400
Equipment	-0-	-0-	5,000	4,000	4,000
Special Council Contingency	-0-	-0-	-0-	51,200	40,000
TOTALS	594,450	582,900	756,150	776,060	772,060
NET GAIN (LOSS)	47,550	(55,200)	(85,950)	(127,360)	(102,610)

†May be considered in Council Contingency.

*Budget as adopted by the HMA Finance Committee and Council

next goal should be to increase income and decrease the debt service by arranging for long-term financing (probably a mortgage).

The delegates are reminded that there has not been any dues increase since 1975, although it was agreed at one time that dues should be increased in incremental stages to keep up with the cost of living.

It is recommended that the delegates give serious consideration to this during this session.

GROVER H. BATTEN, M.D.

Hawaii Medical Association Auxiliary—1976-77

ACTION: Filed

Our main purpose this year has been to take stock of ourselves and consider how we are progressing in order to decide in which direction we should be going now and in the future.

This has been a year of retrospect and analysis. As a result we hope to give our auxiliary new life and purpose. Honolulu County appointed a Special Evaluation and Future Planning Committee to investigate the need for change and reassessment. Our Workshop in February followed up on this theme of Reorganizational Renewal, and we hope that our members will benefit with updated thinking and a refreshing new outlook.

Our four component auxiliaries have been busily involved in many community health projects. They have worked on Immunization, the Blood Bank, Cancer Society, Health Screening for the Elderly, Mentally Handicapped, CPR courses, Tape Reading for the Blind, Informational Baby Packets for new mothers in the hospitals, assisting Hospital Auxiliaries, etc. Honolulu County's Guest Day seminar this year entitled "On Life & Death—A Day of Reflection" was especially well received by over 400 community leaders and is scheduled to be written up in the AMA National publication "M.D.'s Wife."

All counties participated in fund raising projects for AMA-ERF with a yearly picnic, selling stationery and baked

HMA Committee Budget Requests

Legislative

Legal Counsel	8,500
Today's Health	300.00
Miscellaneous	400.00
Printing	<u>1,500.00</u>

10,700.00

Public Affairs

News Media Award	800.00
Science Fair	200.00
Tel-Med	6,000.00
Miscellaneous	<u>50.00</u>

7,050.00

TV-Radio

Video Cassettes	1,500.00
Production Costs	<u>1,500.00</u>

3,000.00

Worker's Compensation

May need legal fees for Worker's Fee Schedule hearing

-?-

Fee Survey

Printing of RVS	20,000.00	20,000.00
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Sports Medicine

Seminar for Coaches, Trainers Refreshments, printing, publicity, etc.		60.00
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Medical Education

Publications Calendar	4,800.00
Xerox, Printing, Postage	2,500.00
Secretary	4,000.00
Travel & Per Diem	400.00
Consultation	1,000.00
HMA Award Printing	1,000.00
Miscellaneous	<u>200.00</u>

13,900.00

54,710.00

goods, etc. Maui County continues to support its scholarship fund with a gourmet benefit to raise money for local students to attend the medical school of their choice. The 3 current recipients are enrolled in the University of Hawaii School of Medicine.

International Health has been as busy as ever and our Honolulu County Chairman has sent 3,800 lbs. of medical supplies and equipment to Saigon, Zambia and the Philippines. The need to entertain foreign doctors who are visiting or in training here has been stressed. Kauai County continues its support of Project Hope.

Again on account of our tight budget only two issues of "Rx for M.D. Mates" were possible, although we approached another lower cost printer for the second publication. We hope to be able to resume our regular three mailings next year.

We have three members who faithfully attend legislative meetings and hearings for the State. All members have been urged by our chairman to write letters, especially concerning the passage of the Comprehensive Health Care Insurance Act of 1977.

WASAMA, now temporarily known as "Young Physicians' Wives," is active in its own group but continues to assist our auxiliary with the Cookbook project and also joined our members in helping with the fall HMA Convention. We welcome their participation and have invited them to send a representative to our State Board meetings.

For the first time funds were allotted for two of our neighbor island presidents to attend one of our State Board meetings which enabled them and our Board members to achieve closer liaison and better understanding—successful communication in action. We hope that this will be a future continuing policy. Also the Executive Secretary of the HMA has now agreed to be present at our Board meetings to lend us his direct support and advice.

Thanks to the unfailing response of our dedicated members our auxiliaries continue to leave their important mark on the health concerns of our communities.

MRS. C. ARTHUR ROSSBERG,
President, HMA Auxiliary

Building Committee

ACTION: Filed

The Hawaii Medical Association has had about one year experience in operating its building at 320 Ward Avenue. The year has been a very busy one. The increased operational activities of the Association and the other organizations that occupy space at 320 Ward has resulted in a high usage of the building facilities. For example, during the period November 1976 to October 31, 1977, 539 meetings were held in our new building. 320 Ward Avenue has given the Association increased flexibility to accommodate such demands and provide more convenience for its members, such as more parking space. Even with the large number of meetings, parking problems have been minimal.

The increased operations of all the physician organizations housed at 320 Ward has required the reallocation and rearrangement of equipment and personnel spaces. The rapid expansion of HMA's staff due to PSRO requirements has required the use of an additional 500 square feet in Suite 204. Tenants are also experiencing growth, and we have seen the expansion of National Escrow and Locations, Inc. by 300 and 700 square feet respectively. The building is now fully occupied.

Cash flow is positive. The cash requirements to operate the building have been fully met by the lease rents received

With much of the effort during the first year being focused on settling into our new home, it is now time to look to the future. During the next year, efforts will be concentrated on programming major maintenance expenditures to ease resource requirements. Also, financing alternatives to the building funds will be considered and after study brought to the Council. One area that will be considered will be the possible refinancing of the current Agreement of Sale with Blackfield. However, nothing is firm at this moment.

CALVIN C. J. SIA, M.D.

Legal Counsel

ACTION: Filed

This report covers the 12-month period October 1, 1976 to September 30, 1977, during which your legal counsel attended the 1976 meetings of the Caucus of Oahu Delegates and the House of Delegates and several Council meetings, and handled administrative calls, correspondence, and matters for the Association as required by your staff and officers.

The subjects on which we conferred included questions relating to and review of the Peer Review difficulties being experienced by some county societies; continued background work on the proposed medical malpractice legislation; doing research and expressing opinions on EMS and PSRO program questions, including a suit against officers of the Association arising from the EMS program involvement subsequently referred to counsel selected by the Association's insurance carrier; review of the effect of amendments to the Medical Malpractice Act; review of questions raised by the Federal Trade Commission; review of the Cancer Center and the Association's relationship with it; examination of the relationship of Association and Society Peer Review relationships with the Board of Medical Examiners; examination of the Association's insurance program; and general administration questions.

Major projects, hopefully not repetitive, involved three court actions, one relating to the compulsory malpractice insurance, one relating to Mabel Smyth which is still pending at a low intensity level, and the one relating to an EMS student now being serviced by other counsel. The incorporation of the Hawaii Tumor Registry was also completed during this period. There has been and there will be ongoing involvement in operational problems relating to leases of portions of the 320 Ward Avenue building.

Your legal counsel has no recommendations and has no budget request.

V. THOMAS RICE, *Attorney*

Hawaii Foundation for Medical Care

ACTION: Filed

The Hawaii Foundation for Medical Care, a subsidiary of the Hawaii Medical Association, has been relatively inactive for the past year, with the exception of the Roofers Union Foundation Health Plan. The Roofers Union representatives met several times with the HMA Executive Director on the future of the Roofers Union Plan and they decided, as of June 30, 1977, to cancel the Roofers Union Plan in favor of other commercial carriers. Notices of the termination of this Foundation Plan were sent to all Foundation and HMA members.

At the HMA House of Delegates, 1975, Resolution No. 11 was adopted which asked that the Foundation Board of Directors explore the possibility of functioning as a statewide HMO. One meeting was held in 1976 but no action was taken. During 1977, a staff report was prepared outlining the current status of HMO legislation and the possibility of establishing an HMO within the Hawaii Foundation for Medical Care.

The Foundation Board also discussed the future of the Hawaii Foundation in light of the fact that without the Roofers Union Plan, the Hawaii Foundation has no current ac-

tivities. The Board makes the following recommendations to the House of Delegates.

Recommendation:

- (1) Although the Foundation believes that an HMO is feasible, it questions the desirability of the HMA sponsoring an HMO. The Foundation, however, encourages physicians to develop their own HMO programs, and the Foundation would be willing to assist and provide information on federal grant monies available.
- (2) That the Hawaii Foundation for Medical Care continue as a corporation.

WINFRED Y. LEE, M.D.

Mabel L. Smyth Memorial Building

The following individuals represented the Hawaii Medical Association on the Mabel L. Smyth Memorial Building Board of Management for the year 1977: Dr. Elmer C. Johnson, Dr. Grover Batten, and Dr. Walter W.Y. Chang, *Alternate*.

The following individuals represented the Hawaii Nurses' Association on the Mabel L. Smyth Memorial Building of Management for the year 1977: Mrs. Rosie Chang, Mrs. Sandra Chung, and Mrs. Althea Kamau, *Alternate*.

The following individual represented Queen's Medical Center on the Mabel L. Smyth Memorial Building Board of Management for the year 1977: Mr. Lester Gamble, *Chairman*.

Building Improvements:

1. The Board of Management approved a contract to have the second floor repainted after the Hawaii Medical Association moved to 320 Ward Avenue.
2. Queen's Medical Center took occupancy of the space vacated by Hawaii Medical Association in December 1976. Their maintenance fee for the space provided commenced in September 1976. The Board of Management approved the following improvements to the second floor area, expense borne by Queen's Medical Center.
 - A. Acoustical Ceilings in all rooms.
 - B. Carpeting of the entire second floor, including hallway.
 - C. Construction of a new storage room at the back of Mabel Smyth Building.

Building: (Other Items)

1. In February 1977 Queen's Medical Center registered interest for full time occupancy of the Lanai area. The Board approved their request. Queen's Festival of Trees volunteer workers took occupancy in May 1977.
2. In May 1977 the Hawaii Nurses' Association initiated litigation involving Hawaii Medical Association and Queen's Medical Center concerning conduct of the Mabel Smyth Memorial Building Board of Management.
3. Lawyers representing Hawaii Nurses' Association and the Hawaii Medical Association reviewed pertinent documents relating to the litigation in June.

Nurses & Physicians Exchange:

1. The Nurses & Physicians Exchange moved to their new office at 320 Ward Avenue in December 1976.
2. Tel-Med and the Hawaii League for Nursing are sub-renting space from the Exchange at 320 Ward Avenue.

Motorola Radios:

1. Voice receiving radio subscriptions have increased from 256 in 1976 to 304 in 1977.
2. Monthly radio messages have increased from 32,816 for 1976 to 44,206 or 35% in 1977.

Activity Reports:

1. A total of 407,322 telephone messages were processed during the year. This represents an increase of 5,225 calls per month or 15.4%.

Membership:	1976	1977
Physicians	400	426
Registered Nurses	50	51
Licensed Practical Nurses	15	16

GROVER H. BATTEN, M.D.

HAMPAC

ACTION: Approved

The activities for HAMPAC during the off-year 1977 have been primarily directed towards membership and physician education. We initiated the physician political education workshop held February 5, 1977 at the Sheraton-Waikiki Hotel. Approximately 65 physicians and spouses attended as well as five legislator speakers including state representative Lisa Naito and U.S. Senator Daniel K. Inouye.

The membership drive was pushed on a concept of eyeball to eyeball contact and followed the rule of eleven as mentioned in the political workshop. The results of the membership drive showed a total membership as of September 30, 1977 of 310 including 32 spouse memberships and 14 sustaining memberships. This is compared to a total membership as of November 30, 1976 of 242 which included 13 spouse memberships and 2 sustaining memberships. As a result of our excellent increase in sustaining members, the Hawaii delegation was recognized at the AMA Annual Meeting by receiving a special recognition award by having every member in the delegation a sustaining member of AMPAC which placed Hawaii as one of the six states in the nation receiving this award.

Proposed activities for next year include a public affairs workshop in February which will attempt to address the matter of legislative concern and will be open to all physicians and interested members of the lay public. We also plan a political workshop in September to educate physicians and spouses as to how they may become directly involved in the political process.

In order to carry out the proposed activities for the coming year, we are submitting a proposed budget in the total of \$1,000 for the 1978 educational fund. In line with the recommendations of the Leadership Workshop in October, we would recommend that the HMA leadership continue their strong support of HAMPAC and encourage all members of the medical community to become sustaining members.

LEONARD R. HOWARD, M.D.

Election

ACTION: The report of the Nominating Committee was presented and the President called for nominations from the floor. There were no further nominations. Ballots were distributed and Drs. Peter Kim and Thatcher Magoun were appointed tellers. The following were elected:

President-elect	George Goto
Treasurer	William Hindle
AMA Delegate	Herbert Y. H. Chinn
Alternate AMA Delegate	William E. Iaconetti
Councillor from Maui	Denis Fu
Councillor from Hawaii	Arch Wigle
Councillors from Honolulu	Felix Lafferty
	Leonard Howard
	Alexander Roth
	Neal Winn

The Nominating Committee was elected as follows: Herbert Chinn, William Dang, Andrew Morgan, Calvin Sia, and Patrick Walsh (Honolulu); Sakae Uehara (Maui); Richard Lundborg (Hawaii); Peter Kim (Kauai).

New Business

ACTION: The House of Delegates voted to commend Dr. Sia and give him a standing ovation for his outstanding leadership as HMA President.

The meeting adjourned at 5:30 p.m.

DOUGLAS B. BELL II, M.D.
Secretary

Nominating

ACTION: Approved

The Nominating Committee met to receive nominations for needed offices of the Association. The following slate of nominees was submitted to be elected by the House of Delegates:

President-elect	George Goto
Treasurer	Grover H. Batten, William Hindle
AMA Delegate	Herbert Y. H. Chinn
Alternate AMA Delegate	William E. Iaconetti
Councillor from Maui	Denis Fu
Councillor from Hawaii	Arch Wigle
Councillors from Honolulu	Felix Lafferty
(4 to be elected)	Leonard Howard
	Alexander Roth
	Neal Winn

All nominees have been contacted and have agreed to serve if elected.

ANDREW L. MORGAN, M.D.

Awards

Medical Journalism

Tomi Knaefler—Honolulu Star-Bulletin
Special Public Relations Awards
Oceanic Cablevision for production of HMA television programs.
Honolulu Star-Bulletin for the weekly Health Page
KGMB for production of MEDIX

A. H. Robins Award

Harry L. Arnold, Jr.

Sportsmen's Awards

Tennis:
Benjamin Chang-Dennis Maehara—Doubles champions
Gene Doo—Singles champion
Fishing:
John Peyton
Golf:
President's Trophy—Henry Yokoyama
Robert M. Miyamoto Perpetual Trophy—Henry Yokoyama
John M. Felix Perpetual Trophy—Albert Chun-Hoon
George H. Mills Perpetual Trophy for Pharmaceutical Representatives—Roy Tanabe



The Department of Health, Education and Welfare published in the Federal Register of 23 Sept 1977 the "Advanced Notice of Proposed Rulemaking" for National Guidelines for Health Planning. The deadline for response from the public, originally set for 22 November, was extended recently to 8 December. Physicians have been urged by their societies to review and comment.

A careful perusal of PL 93-641 discloses that in "Findings and Purpose" in the law, the U.S. Congress stated that achievement of "equal access to quality health care at a reasonable cost is a priority of the Federal Government." This is further expanded to include concern for access to services and quality of care, with the concern for problems of cost being rather secondary in that the law stipulates that there be no constraints placed on these.

The Guidelines proposed by DHEW, on the contrary, seem to subvert the intent of Congress, by emphasizing an avowed purpose to reduce costs as their primary purpose, to the distinct detriment of both accessibility and quality. The Guidelines are listed under Roman Numeral headings:

I and II—A Reduction in acute-care, general hospital beds so as to obtain higher occupancy rates. In the State of Hawaii, in order to obtain an average occupancy rate of 80% mandated by these guidelines, it would mean doing away with 400 beds. Hospitals would have to put up "no-vacancy" signs and restrict non-emergency admissions much more often than is sometimes necessary now. Patients would, therefore, be deprived of necessary medical and surgical care, or at least have their chances of a speedy recovery and return to good health jeopardized.

The same would apply to:

III—Obstetrical Services. QMC, with approximately 1000 deliveries in its unit in 1976, would have to close the unit since 2000 deliveries per annum is to be required in a hospital serving a SMSA (Standard Metropolitan Statistical Area). Wahiawa, Castle and Kaiser would have to close theirs because they are within the mandated 45-minute travel time from Kapiolani. One can just hear the howls of the gravidae!

IV and V—Pediatric Services. Only Children's and QMC now qualify to have Ped units. All other Oahu hospitals would have to phase their units out. In fact, even QMC would not qualify under the guidelines because its 1976 occupancy rate in peds was only 25.5%—the mandated rate is 65%.

VI—Neonatal Intensive Care. Children's, with only 12 beds in INCCU, would not qualify, perversely, because a minimum of 20 such beds for an HSA (Health Systems Agency) population of 1 million would be mandated, and no exception for travel time allowed.

VII—Open Heart Surgery. QMC had 312 such in 1976; Straub had 110. Since QMC did not

meet the minimum of 350/year, the Straub unit would be disqualified. Only if QMC's incidence rose above 350/year, would Straub or St. Francis or Kuakini be allowed to have a team, and then only if a team performed more than 200 cases a year right off!

VIII—Cardiac Catheterization. The restrictions would be proportionate.

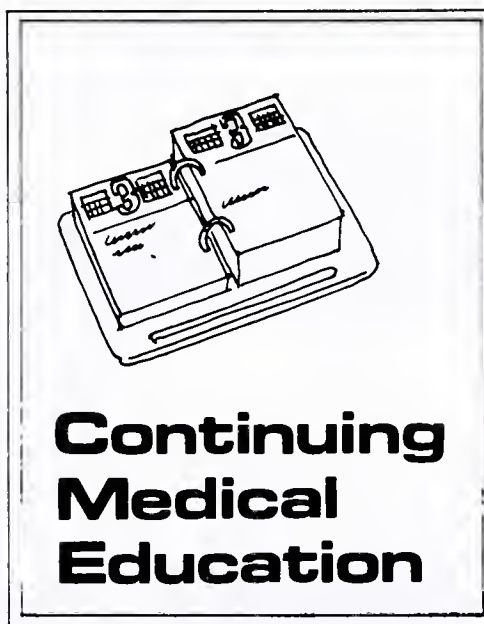
IX—Radiation Therapy. In the entire State, only QMC could qualify. The unit in Hilo would have to close, thus forcing all Big Island cancer patients (and from the other islands as well) to go to the expense of travel to and stay in Honolulu, or go without.

X and XI—CAT-Scanners and the Renal Dialysis Units. The almost-essential modern use of these modalities would be similarly restricted and made *less* available to patients in dire need of such services.

There isn't any doubt that these Proposed Guidelines would lower the cost of health care services! The cheapest way to save on food is to not eat any!

Thus does an all-powerful bureaucracy subvert and pervert the intent of Congress. It is up to the people—and their physicians—to wake up to this realization, and to call upon their government to remedy the situation.

JIFR



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

1. G.I. Conference, 4th Tues., 8-9 a.m.
2. Medical Mortality & Morbidity, 4th Tues., 1:00-2:00 p.m.
3. Endocrine conf., 2nd Wed., 1:00-2:00 p.m.
4. Oncology Conf., Every Thurs., 7:30-8:30 a.m.
5. Surgical Mortality & Morbidity, 3rd Fri., 1:00-2:00 p.m.

6. Visiting Prof. Programs.

7. Ophthalmology Dept. Mtg. 2nd Tues., 1:00-2:00 p.m.
 8. Orthopedic Dept. Mtg. 2nd Tues., 8:00-9:00 a.m.
 9. Surgical Conf. 1st & 2nd Fri., 1:00-2:00 p.m.
- (Contact: CME Dept.-Kuakini for further information)

The Queen's Medical Center

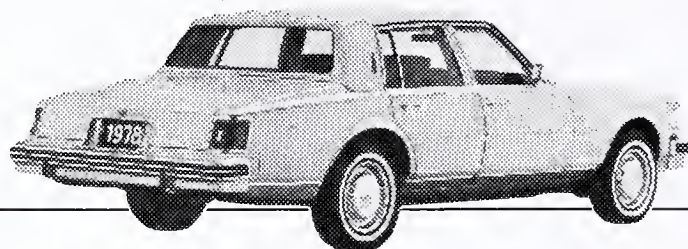
1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.



Prescribe one for yourself.

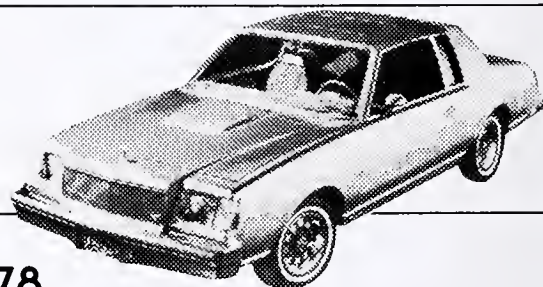


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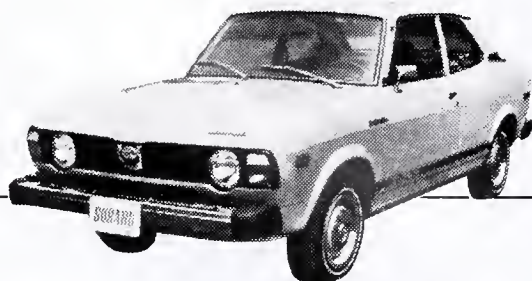
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2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m.
(Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professors' Program.
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

St. Francis Hospital

1. Orthopedic Dept. Conf. 3rd Fri. ea. month. 7:30 a.m.-Med. Staff Board Rm.
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
7. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday,

7:00 a.m.

3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

At: Honolulu County Medical Society and Local Hospitals, Honolulu

Type: I, 1 hr/day, 1 day/mo from 12 mos

Fee: None Methods: AV, O, Pan

Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817

Type: I, 1 hr/day, 1 day/mo for 8 mos

Fee: None Methods: AV, Clin C, O, Pan, R

Dates: Arranged; 8 hrs instruction

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Lawson-Worrall, Inc.	735-2411
Luke & Luke Realty, Inc.	524-7894
Stark Realty Ltd.	955-6302



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SPECIAL EVENTS

- Jan. 9-13, 1978 Fundamentals of Echocardiographic Interp. at Kauai Surf, Lihue, Kauai, HI. 5 days-20 hrs. Fee \$325 or non-members \$375. Amer Coll of Cardiology, 9111 Old Georgetown Rd. Bethesda, MD 20014/U of HI Schl. of Med. Hono Med. Grp.
- Jan. 16-20, 1978 Perinatal Med at Royal Lahaina Htl., Maui, HI. 5 days-30 hrs. U of So. Calif. 2025 Zonal Ave. LA, Calif 90033.
- Jan. 12-14, 1978 Gen. Pediatrics at Kona Surf Htl, Kona, HI 3 days-18 hrs. Amer. Acad OF Ped. 1801 Hinman Ave, Evanston, IL 60201.
- Jan. 21, 22, 1978 "Teaching Skills Seminar," 9 a.m.-5 p.m., Kaiser Aud., AAFP. 8½ Prescribed cred. AAFP or 8½ cred. Cat. 1. Contact: Mrs. Jean Reppun 47-410 Lulani St., Kaneohe, HI 96744 (808) 239-8383.
- Jan. 25-31, 1978 3rd Annual HI Hsp. Med Staff Conf. at Kauai Surf Htl.-Kalapaki Beach. Estes Prk. Inst. Box 400, Englewood CO 80151. 5 days. Fee \$190.
- Jan. 25-31, 1978 Hsp. Trustee Forum at Kauai Surf Htl.-Kalapaki Beach. Estes Prk. Inst. Box 400, Englewood, CO 80151. 5 days-32 hrs. Fee \$190.
- Feb. 1-3, 1978 Post-Conf. Workshops at Htl. King Kamehameha-Kailua-Kona. Estes Prk Inst. Box 400, Englewood, CO 80151. 3 days-10 hrs. Fee \$100.
- Feb. 20-24, 1978 Advances in Pt. Care: Caring for the Older Person at Kona Surf Htl., Box 128, Kailua-Kona 96740. 5 days-31 hrs. Med. Comm. & Serv. Assn., 315 Univ. Dist. Bldg. 1107 NE 45th St. Seattle, Wash. 98105.

- Feb. 27, Mar. 2, 1978 Winter Trav. Med. Educ. Course at Royal Lahaina Htl., Maui, HI. 4 days-10 hrs. Fee \$100. Kansas City SW Clin. Soc. 2220 Holmes St. K.C., MO 64108.
- Feb. 27-Mar. 3, 1978 Clin. Mang. of Sexual Problems at Sheraton-Molokai Htl., Molokai, HI. 5 days-30 hrs. Fee \$195. Med. Comm. & Serv. Assn. 315 Univ. Dist. Bldg. 1107 NE 45th St., Seattle, Wash. 98105.
- Feb. 27-Mar. 3, 1978 Surg. Diagnosis & Therapy at Maui, HI. 5 days-20 hrs. Fee \$300. Phil Thorek Post-Grad Courses, 850 W. Irving Park Rd., Chicago, IL 60613.
- Mar. 14-18, 1978 Sports Med/Primary Phys. at Princess Kaiulani Htl., Waikiki, Hono., HI. 5 days-18 hrs. U. of HI Sch of Med. 1960 E West Rd., Hono 96822 & Amer Acad of Family Prac. Contact: Harold Brown, (808) 373-3745 or 373-3045.
- Apr. 3, 7, 1978 14th Congress Pan-Pacific Surg. Assoc. Hilton Hi Village, Honolulu, HI., 7:30 a.m.-12:45 p.m.. For details write: Cesar B. de Jesus, M.D., 236 Alex. Yng. Bldg. 1077 Bishop St., Honolulu, HI 96813. (808) 536-4911.
- Apr. 17-21, 1978 Emergency Med., 1978 at Royal Lahaina Htl., Maui, HI. 5 days-30 hrs. U of So Calif

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.

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Book Reviews



Handbook of Pediatrics,

By Henry K. Silva, C. Henry Kemp, and Henry B. Bruyn.
Ed. 12. Los Altos, California, Lange Medical Publications, 1977.

The authors have again compiled a very concise coverage of a very broad field of knowledge. They provide readily accessible information helpful in the diagnosis and management of pediatric disorders, which should be especially valuable for students requiring knowledge of the most pertinent and basic information as relates to pediatrics. I feel they have accomplished their goal in providing a great deal of information in a very concise handbook.

The authors deserve congratulations on a job well done.

CARI LEHMAN, M.D.



Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

New Members—Thornton V. Dilcher MD is a new Active member, practicing with Rod Miller in Haleiwa. We also have two new Student members: Michael C.C. Ling, UHSM'81 and Luis J. Ragunton, UHSM'81.

News of Members—Vern Boido and family have moved to Orange Grove in California. Pat Dietrich hit

the newsprint again when reporter Bone of the Advertiser (11/12/77) quoted her opinion on the Liquid Protein Diet; Pat properly advocated strict physician-monitoring of such programs. Tom Cahill shared the speaker's podium at the December HCMS meeting with James Swenson, administrator, SHPDA in discussing State Health Planning.

Annual Meeting—HAFP takes a new departure by incorporating into its annual meeting and election of officers a 2-day seminar: On Saturday, 21 January 1978, at Kaiser Hospital Auditorium, there will be an all-day session on "Teaching Skills," with Mainland guest speakers of known repute. That evening, HAFP holds its banquet at the Ilikai. On Sunday, 22 January, the same speakers will present a program of scientific subjects with the theme: "Continuity of Care in Family Practice." Attendees may accumulate a total of 8½ credit-hours of "P" (AAFP) or Category 1 for the AMA-PRA. To date, Jean Reppun, our Exec Sec, has received 14 advance registrations. John Kelly MD, President of AAFP, will be our guest and will install the new officers at the banquet.

Quote—from the Oregon OAFP NEWS: "Government Can Do It Cheaper? There are ca. 13 million Americans who receive government funds in direct cash, food stamps, housing assistance or medical care; the cost is \$200 billion. This comes out to \$15,000 for every man, woman or child. Recipients, however, collect less than \$3,000 each per annum. The difference is attributable to bureaucratic overhead!"

CME—Remember to sign up for the Georgia AAFP correspondence course in Primary Care of the Newborn, good for 30 hours of "P". The deadline for signing up is 10 Feb 78 and the course starts on 24 April in four 2-week home-study sessions. Pan-Pacific Surgical takes place 1-7 April.



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FRANCIS FUKUNAGA, M.D.

Disseminated Intravascular Coagulation

Disseminated intravascular coagulation (DIC), also known as defibrination syndrome, consumption coagulopathy and intravascular coagulation-fibrinolysis (ICF) syndrome, is not a distinct disease entity but a pathophysiological reaction to a variety of causes. Characterized by a hemorrhagic diathesis, it begins with an accelerated intravascular coagulation and consumption of coagulation factors and platelets, followed by a secondary activation of fibrinolysis to form fibrin split products (FSP) which enhance the hemorrhagic tendency.

Diseases that cause DIC are associated with tissue injury with release of tissue thromboplastin (about 50%), endothelial injury (about 40%) and erythrocyte injury with release of red cell thromboplastin (about 10%). Acute DIC often presents with massive hemorrhage and may be seen in obstetric patients (abruptio placenta, toxemia, amniotic embolism); in infections (meningococemia, gram negative sepsis, viral and rickettsial infections); in toxemias (snake venom, drugs, poisons), shock states (prolonged hypotension); immunologic reactions (incompatible transfusion reaction) and neoplasms (acute promyelocytic leukemia and prostate carcinomas). Chronic DIC occurs when the stimulus persists for long periods as in disseminated malignancies and giant hemangiomas. Chronic DIC is often difficult to recognize because of

the less severe consumption of coagulation factors and the removal of the fibrin split products by the reticulo-endothelial system.

Fibrinolysis is a protective mechanism wherein fibrin clots are broken down for removal by the reticulo-endothelial system. Plasmin causes cleavage of small fragments from fibrin and fibrinogen molecules; the remaining larger piece, Fragment X, is broken down to Fragments Y and D; Fragment Y is further broken down to Fragments D and E. Fragments X and Y have antithrombin activity while Fragments D and E inhibit fibrin polymerization (the process of fibrin clot formation). Fibrin monomers are the result of action of thrombin on fibrinogen and they normally undergo polymerization to form insoluble fibrin. These monomers, however, may form soluble complexes with FSP or fibrinogen, and these complexes have antithrombin or antipolymerization properties. These soluble complexes are detected by the paracoagulation tests where the complex is split to allow fibrin polymerization, resulting in a visible clot.

Understanding the mechanisms of coagulation and fibrinolysis can help the selection of laboratory tests in the diagnosis of DIC. Intravascular coagulation leads to consumption of platelets, fibrinogen, prothrombin, Factors V, VIII and XIII, followed by activation of plasminogen to plasmin resulting in the production of FSP, which form soluble complexes with fibrin monomers.

The laboratory diagnosis of DIC depends upon indirect evidence of thrombin and plasmin activity, since there are no practical direct methods for their measurement. Serial testing is often valuable to show that the process is taking place. As always, the clinical status of the patient must be included in the interpretation of any laboratory test.

Screening tests should include (1) platelet count, (2) prothrombin time and (3) fibrinogen assay. It is considered diagnostic for DIC when all three tests are abnormal; if only two are abnormal, the paracoagulation test or FSP assay should also be positive. The protamine sulfate paracoagulation test detects soluble complexes formed by fibrin monomers with FSP. Assays for FSP require the use of serum because FSP cannot be distinguished from the fibrinogen in plasma. The greatest increases of FSP are seen with intravascular coagulation and thrombotic episodes such as myocardial infarctions and deep vein thromboses. The normal values for FSP are usually less than 8 μ g per ml, but may be affected by exercise and stress. A convenient and sensitive procedure is the Thrombo-Wellco-test that uses latex particles coated with fibrinogen antibody. A 1:5 serum dilution indi-



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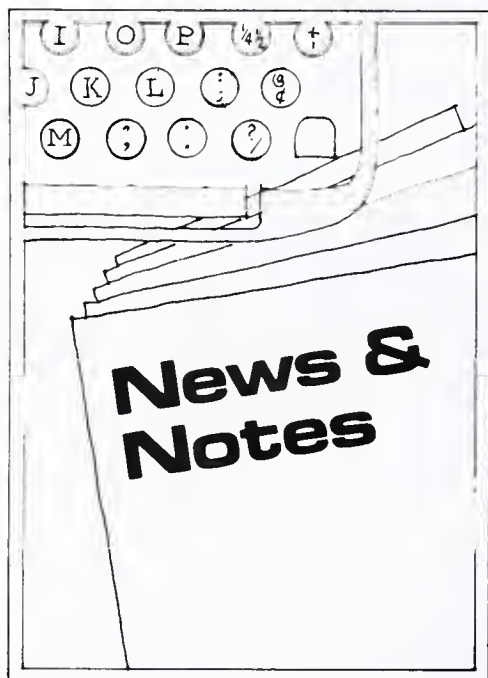
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cates a serum FSP level of greater than 10 μg per ml and the 1:20 dilution indicates a level greater than 40 μg per ml. Other tests include the Tanned red cell hemagglutination immunoassay (TRCHII): the reagents are difficult to prepare and the procedure is lengthy: Staphylococcal clumping test: a strain of *Staphylococcus aureus* clumps in the presence of fibrin monomers or Fragments X and Y (this is an insensitive test). Other time-consuming tests include immunodiffusion, counter-electrophoresis and radioimmunoassay.

Treatment of DIC should be of the underlying process but some cases may require continuous intravenous heparin.



HENRY N. YOKOYAMA, M.D.

Professional Moves

The migration of *Homo Sapiens Medicus* into the Queen's Physician's Building continues unabated . . . In November came pediatrician **Clifford Kobayashi**, internist **Terry Wong**, family practitioner **James Tsuji**, vascular surgeon **Harvey S. Takaki** who joined **Richard Mamiya**, orthopedist **Gerard H. Dericks**, rheumatologist **Melvin Levin**, pediatrician **Richard Ho**, ENT man **Walter Young** and internist **Thomas Min** . . . In other parts of Honolulu, orthopedist **Gerald Mayfield** joined the Straub Clinic, gastroenterologist **Gerald A. Hiatt**

joined the Fronk Clinic Pearlridge, nuclear med man **James John Ball** opened another office at 1319 Punahou St. and the Natori, Teruya and Li, MD's Inc. relocated their Aiea office to the Pearlridge Office Center. On Maui, ophthalmologist **Robert Hayes** joined **Harold Kushi** at the Maui Clinic, Kahului . . .

In the October issue, we quoted from a newspaper article that the Fronk Clinic had purchased the Leeward Hospital . . . We stand corrected by Pearlridge Hospital medical director D.R. Canete that Fronk Clinic had purchased the Leeward Medical Clinic adjacent to the hospital and the fee simple 4.2 acres where the hospital stands, but that the hospital itself is a non-profit organization belonging to the community in Aiea . . .

Sportsmen

A golf weekend to forget . . . or how can so many things go wrong?

Paul Tamura had carefully planned a weekend of golf in Kona with three golfing friends . . . First of all, **Art Salcedo** catches the wrong plane on the wrong airline and when Art reaches the hotel, he opens up his luggage and out comes women's apparel . . . Art naturally insisted on going back to the Airport post haste to retrieve his own luggage . . . Well, Paul, **Sam Yee** and **Gabe Ma** go down to the Keauhou Golf Course around 9 am only to discover that they had had a 7 am tee time . . . After mucho haggling and waiting, they finally got to play. That evening, tired, frustrated, and hungry, they had to wait 2 hours before the food came. Meanwhile they whiled the time drinking . . . Which probably explains how Sam Yee, next day at the Kona Airport, started coffee ground emesis and also somehow got himself locked in the toilet . . . So there was poor Sam, locked in a toilet, vomiting blood . . . and with two pathologists and an orthopedist as attending . . . Somehow, they managed to get Sam out of the locked toilet and into Kona Hospital where Sam received 4 units of blood. Now, how did we learn all this when no one would volunteer such embarrassing information? . . . Well, it happens that **Cool Wakai** was playing golf on Sunday at Waialae GCC when he was called off the course for an emergency telephone consult at Kona Hospital . . . But please don't ever ask Paul about his lost weekend because he would screw up his face with that same pained expression we remember so well whenever he tells of his first post-hemorrhoidectomy bowel movement . . . oh, so many years ago . . .

We have only a preliminary report on those physicians who finished the grueling Honolulu Marathon 1977 held Dec. 11 . . . Thus far we have **Sharon Bintliff**, **Ed Kagihara**, **Dick Ando**, **George Starbuck**, **Jim Harrison**, **Jiro Sayegusa**, **Jerome Tucker**, **Fernando Atienza**, **Hunky Chun**, and naturally **Jack Scaff** and **John Waggoner**. We hope to have a complete listing by the next issue . . .

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The Mid-Pac Thursday Club held their annual windup banquet at the Maple Garden . . . **Bob Oishi** who shot nets 66 and 66 on two Thursdays won **Vic Mori's** Presidential Trophy. MC **Mike Okihiro** gave **Alan Luning** "The most improved golfer" award because his handicap had dropped from 14 to 11 during the year and **Herman Mercado** was voted the 2nd most improved golfer for dropping from 13 to 11. The Club's worst putters had 3 nominees: **H. Yokoyama**, **Ed Izawa** and **Masaru Koike**. The vote was unanimous for H. Yokoyama and his now famous yipping putts . . . The lowest gross score of the year was Mike Okihiro's gross 71. The three nominees for "The golfer who best vents his emotions on the course" were **Garth "Garth dammit" Morimoto**, **Herb "Ah Shit" Takaki** and dentist **Lionel "club thrower" Furukawa**. The voting was too close to reach a decision so a tie was declared and all three received bottles of wine for the honor . . .

Pete Okumoto of Hilo swam in the 60-64 age group and finished 6th in both the 50 and 100 freestyle events in the recent 1977 National Masters AAU Long Course Swimming Championships held in Spokane, Wash. Pete reported that there were 550 participants from 84 clubs in the U.S. . . . "It was my first attempt and probably my last at the Master's . . . You sit around and wait for your heat in the cold and your lips start to shiver . . ." he complained . . .

Another physician swimmer is 62-year-old **Harold Sexton** who is active throughout the Master's season which starts in early March and culminates in the Waikiki Roughwater Swim. The Waikiki Roughwater Swim was started in 1970 with 36 entrants and this year, there were 300 entrants . . .

Dale Adams who originated the first annual Molokai-to-Oahu Kayak Race had to drop out due to injury 4 hours into the race. The winner, a Dean Hayward, made it in 6 hours, 43 minutes.

Life In These Parts

A 47-year-old rather obtunded obese oriental woman with mild hypertension was making no progress on her weight reduction program even with appetite suppressants . . . After several frustrating visits, we had the temerity to ask, "How much have you cut down on your food intake?" Much to our chagrin, she replied, "I've taken your pills faithfully every day . . . but you didn't tell me to eat less . . ."

The Ralph Nader group in Washington headed by a Sidney Wolfe claimed that fellow pathologists across the nation had misdiagnosed breast cancer in 64 women, that 58 of them had surgery, and that Honolulu pathologists had misdiagnosed 4 breast cancer cases. **Fred Gilbert**, director of the Pacific Health Research Institute, reported that our pathologists will stand behind their original diagnoses and will send further biopsy and slide materials to Washington to back up their original conclusions . . . Our pathologists all agree that as cancer of the breast is diagnosed in its earlier and more curable stages, there may be disagreements among experts . . .

Kohala with its economic problems is losing one of its two physicians . . . **Charles Morin** has succumbed to "the intolerable economic situation" and the "callousness of federal, state and county agencies." The other physician, **Michael Padwick**, is also winding down his practice. When he leaves, Kohala residents will have to travel 30 miles for emergency care . . .

Orthopedist **Gabe Ma** has a new technique, the "Ma Procedure" for repairing ruptured Achilles tendons. Instead of exposing the tendon through the usual long incision, Gabe sutures the tendon in criss-cross pattern via six needle holes, then applies a short leg cast for 8 weeks . . . (Akamai, eh?)

In the wake of the FDA warning that liquid protein was responsible for at least 10 deaths, Patricia Dietrich, physician adviser to the Honolulu Weight Control, Inc. says that hundreds of people have gone through their program safely using liquid protein as directed. She does agree with the FDA's plans for stringent measures to control the distribution of liquid protein . . .

UH biochemist Fred Greenwood reported that 10 local women were in a study testing a new IUD which releases minute amounts of progesterone that curiously enough acts as a contraceptive. The new IUD called "Progestasert" or an "intrauterine progesterone system" have to be replaced once a year. Fred with typical Greenwoodism says the product "works well, is tolerated well by patients and doesn't have any systemic effect like the pill, which is an endocrine bomb."

The State signed a 5-year contract with the National Cancer Institute which is estimated to cost \$13.2 million with ½ paid by the Federal government. The program will be called the Community Cancer Program and will be administered by the U of H Cancer Center of Hawaii. Participants include the American Cancer Society, the Pacific Health Research Institute, Queen's Medical Center, St. Francis Hospital, the Kuakini Medical Center, Kaiser Hospital and Straub Clinic. Hawaii is one of six areas in the U.S. awarded the 5-year contract . . . The program director will be Robert Hasterlik . . .

"George Cerny, a 40-ish New York bachelor, was suffering with heart problems when he picked up a Time magazine months back and read about Hawaii's 'world class' heart surgeon, **Dr. Richard Mamiya**. At that moment, he decided the Isles were his medical salvation. A couple days ago, George showed up at Queen's, was operated on and is now recuperating . . ." (A Daacon item)

Stephen Jackman of Kailua, Oahu was probably one of four who drowned by being swept out to sea off Hanakapiai, Kauai in late October. Tripler intern **Brian Johnson** lost his woman companion while wading in shallow water off Hanakapiai. A large wave came in and pulled them both out . . . Brian barely managed to reach a ledge 50 feet from shore, but she was less lucky . . .

Julia Tsuei, U of H associate OB Gyn professor, reports a 78% success in her 48 cases in inducing labor by acupuncture and one failure in arresting premature labor in her 12 cases . . . The acupuncture points for stopping the premature labor are at the root of the big toe on both feet and the points for labor inducement were in the ankle and between the thumb and index finger on both hands . . .

With Federal funds for training personnel in emergency medical services scheduled to run out in 1978, the HMA, **Livingston Wong**, former EMS head and **Sylvia Levy**, EMS consultant, are pushing for a fee for service plan. It is estimated that 93% of Hawaii residents pay for medical insurance which would cover the cost of ambulance service and at least 50% of the patients carried by the City ambulances were covered by Medicare and Medicaid.

Officials of the Pearl Harbor decompression chamber report a startling rise in cases of bends and air embolism among local scuba divers. There were 61 cases last year and 73 thus far by November this year . . . And 98% of the cases involved civilians . . . The rise reflects the increase in divers and perhaps more divers seeking treatment . . .

Ophthalmologist **Gerald Faulkner** reported at the HMA annual meeting that in his series of 100 regular cataract operations in 1972, 92.5% got 20/40 or better vision with the use of thick glasses, but in his latest series of 220 operations using the new intraocular lens, he reports 96% with 20/40 or better vision, and 25 to 30% of the patients do not need glasses. The average age of his patients was 68 . . .

Elected, Appointed, & Honored

We congratulate our new HMA officers, viz president **Marion Hanlon**; president-elect **George Goto**; treasurer **William Hindle**; AMA delegate **Herbert Chinn**; alternate delegate **William Iaconetti**, and our new councilors, Maui's **Dennis Fu**; Hawaii's **Arch Wiggle**; and Honolulu's **Felix Lafferty**, **Leonard Howard**, **Alex Roth** and **Neal Winn** . . .

Our Journal editor for 36 years, **Harry Arnold Jr.**, received the coveted annual A.H. Robins Award for Community Service. Harry lists among his achievements past presidencies of the American Academy of Dermatology, the Pacific Der-

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matology Association, the HMA and HCMS. Also honored at the annual banquet was Star-Bulletin medical writer since 1953, Tomi Knaefler, who won the annual award for outstanding medical journalism which includes a \$400 cash award. The Public Affairs Committee chaired by **Phil McNamee** is to be congratulated for their choices for the A.H. Robins and the outstanding medical writer awards . . .

Audrey Mertz was one of 5 women honored at the first Leader Luncheon sponsored by the YWCA of Oahu. Audrey, chief of the Mental Health Services Division, has served as deputy director of the Health Dept. and is local chapter president of the National Organization of Women . . . **Mamoru Tokufuji, John Withers** and **C.E. Probst Jr.**, team physicians for Maui High School, were honored for their "many, many years of continuous dedication and voluntary services to the athletes of the school" before 6,000 fans during a homecoming game festivities . . . **Manas Ghosh** of Hilo was among 1,700 initiates who became Fellows of the American College of Surgeons . . . **John McDermott Jr.** was elected councilor of the American Academy of Child Psychiatry. John is chairman of the U of H Medical School Dept. of Psychiatry and was recently elected chairman of the Child and Adolescent Section of the World Psychiatric Association and was appointed to the Council of Child Psychiatry of the American Psychiatric Association . . . **Bertram Weeks** is fund chairman of the Ka Lima O Maui's \$25,000 fund drive . . . **Richard Noda** was one of the founders back in 1962 of the Jack Rabbits (a Waipahu club of about 1,500 boys and girls, ages 6 to 18½) which was formed to "inspire youth to practice the ideals of sportsmanship, scholarship and physical fitness . . ." The Hawaii Medical Library had dedicated a **Grover Batten Room** for Grover who has been on the library's board of governors for the past 20 years . . .

Hors De Combat

Both the AMA and the American Bar Association issued a joint appeal to Congress and to state legislatures in November to repeal criminal penalties for use of pot . . . "We believe the time has come to liberalize laws regarding the possession of marijuana for personal use . . . In too many states, statutes exact punishment that far exceeds the crime . . . Like President Carter, we do not condone the use of marijuana, but we do ask for reason and moderation in state as well as federal laws that seek to control its use . . ." **John Budd** AMA president and William Spann ABA president made the joint appeal . . .

Legislation has been introduced in Congress to enable hospital interns and residents to join a union, but Honolulu medical and surgical residents feel that there is no need for a union here . . . Ivanhoe Naiwi, president of the local AFL-CIO Meat Cutters union offered assistance for Hawaii resident physicians to unionize, "Well, you could say that they're technically meat cutters."

Former Hilo psychiatrist **C. Stanard Smith Jr.**, whose medical license was revoked last May, recovered \$28,500 from the State in unpaid Medicaid money after a one day trial before Circuit Judge Yasutaka Fukushima . . . Stanard lost his license on the recommendations of Darryl Y.C. Choy, hearings officer with the State Department of Regulatory Agencies for "gross carelessness and professional misconduct" in prescribing large amounts of amphetamines and narcotics . . . The recommendations were approved by the five doctor members of the nine member board . . .

Darryl Y.C. Choy announced in October that the State had called and examined 17 witnesses including rebuttal witnesses and the defense called 20 witnesses in the three weeks of closed testimony regarding the State petition to revoke **Richard You's** license. Richard is charged with "professional misconduct and gross carelessness" in prescribing large amounts of drugs to his patients . . .

The AMA and other organizations including the United Churches and many women's organizations are actively campaigning against TV violence . . . Statistics quoted are as

follows: Children between ages one and five spend 3 hours a day watching TV 20 days a month . . . The average TV set is on six hours a day . . . During a full day's viewing, a child has a chance to observe 42 anti-social acts . . . By the time a child reaches 18 years of age, he will have had an opportunity to witness 18,000 murders . . .

Entrepreneurs

"**Dr. E. Gordon Dickie** has done it again—he's come out with a new book called, 'Listen to the Animals.' He describes it as '200,000 words and no sex.' He's off to the Mainland to promote the book. When does he find time to read all the books and magazines in his 30 pages of bibliography? 'I get up at 2 am and read,' he explains." (From Donnelly's Column . . .)

Richard S.F. Lam of Pacific Ambulance which won the bid for the Waimea Bay to Punaluu promises upgraded ambulance service for the North Shore residents starting September. The contract calls for mobile intensive care technicians for only eight hours a day . . . but Richard will have intensive care technicians on for 16 hours a day . . .

Robin Cook who interned and took part of his surgical residency at Queen's Hospital from 1966-68 has published his second book, "Coma" which is a Literary Guild selection for the summer and is slated for filming by MGM. Robin is a practicing ophthalmologist at the Massachusetts Eye and Ear Infirmary and a clinical instructor at Harvard Medical School. Robin's first book, "Year of the Intern" was published in 1973 and preached a need for more humanistic approaches and concerns in the training of interns . . .

ENT man **Roger Netzer** at Wilcox Memorial Hospital has been breeding Beefalo (a cross between the cow and the American buffalo). Beefalo can grow to market weight rapidly on grass and need no grain. It also is higher in protein and lower in cholesterol.

John Kim, chief of Kaiser's department of medicine explained their "team care approach" wherein a patient is assigned to a team of four physicians (viz three internists and a general practitioner). With the team care approach, a patient sees one of four doctors, so that when one physician is away, any of the other team members can provide uninterrupted care . . .

Al Luning's Corner

Two business executives were having lunch . . . "Say, what happened to your attractive secretary?" "Oh, you mean Betty Lou . . . Had to fire her." "Why? She was a great secretary . . ." "Well, last week was my 49th birthday . . . Got up in the morning and no one said anything . . . Got to my office and Betty Lou gives me a big smile and a kiss and says, 'Happy Birthday, boss!!' . . . So I took her to lunch and we had a few drinks . . . Then Betty Lou says, 'Boss, it's a shame to go back to the office . . . Let's go up to my apartment and we can really celebrate your birthday . . . ' So we got to her comfortable flat and she says, 'Help yourself to the bar while I freshen up a bit and get into something more comfortable . . . ' So, anticipating the best, I poured a tall cool one and made myself comfortable on the large sofa . . . Then surprise of surprises! Out parades Betty Lou with my wife and two kids singing 'Happy Birthday' and carrying a birthday cake with candles lit and everything . . ." "Guess it was a big surprise, eh?" "You bet! Here I was sitting on that big sofa, drink in hand and clad in my birthday suit . . ."

The new recruit had just arrived at this desolate desert outpost of the Foreign Legion. During the indoctrination, the new legionnaire asked his commanding officer, "Sir, what does one do when he needs a woman?" The officer explained, "Well, you can always jump on a camel . . ." The legionnaire looked rather dismayed then resigned . . . One late evening a week later, there was all this commotion in the camel stalls and the commander went to investigate. There was the new re-

cruit jumping up and down on a camel and the animal was voicing her annoyance . . . "What are you doing?" demanded the commander. "Sir, you told me to jump on a camel." "I meant you can jump on a camel and ride into town which is only 10 miles away . . ."

Miscellany

Jim was deer hunting on Molokai with Bob. When climbing over a fence, he accidentally shot himself in his foot. Bob rushed him to Doc Stevens who examined the foot and declared, "I may have to give you general anesthesia so I can work on your foot." "Go ahead Doc! I can stand any pain after my second worst pain," said Jim. Doc asked, "What was your second worst pain?" "Well, I was hunting in Alaska one summer, and I squatted to crap, when my testicles got caught in this well-hidden bear trap." The Doc grimaced and his curiosity aroused, inquired further, "What was your first worst pain?" "When I came to the end of the chain . . ." was the terse reply . . . (As told by **Alan Luning** at the Mid-Pac 19th Hole)

The disheveled drunk staggered into the local police station to report a stolen car. The sergeant asked, "Where did you last see your car?" The drunk pulled out his car key and chain and replied, "At the end of this chain." The sergeant, a little annoyed, noticed that the drunk's fly was half open . . . "Why don't you zip up and come back when sober . . ." The drunk looked down at his open fly and remarked, "Hey, they stole my gal, too!" (As told by **Alan Luning**)

A Texan walked into a well-patronized local bar . . . After a few drinks, he boasted aloud that he could make any horse laugh and he was willing to wager \$500 . . . The patrons of the bar quickly put up \$500 and called his bluff. Someone went out and got his horse. The Texan went up to the horse and whispered into its ear . . . The horse laughed and laughed and nearly died laughing . . . The happy Texan collected his winnings and walked out before the amazed audience . . . The next evening the same Texan sauntered into the same bar with the same customers drinking. One patron eager to win his money back told the Texan, "I bet you can't make a horse cry!" The Texan bragged, "I sure can and have \$500 to prove I can." The customers raised another \$500 and put up the \$1000 on the bar counter again. The cowhand went out to get the same horse. The Texan asked, "Let me take the horse out in back for a few minutes. We'll be right back." He leads the horse out into the back alley and returns in a few minutes with a saddened horse with tears rolling down in torrents . . . The happy Texan collects his winnings and was about to go. The curious cowhand asked, "How did you manage to make my horse laugh one night and cry the next?" "That's easy . . . I first told him that I had a bigger — than he had and that made him laugh . . . Then tonight I showed it to him and he cried . . ." (As told by our golfing pardner **Alan Luning**)

Three drunks were arguing about who besides God could have created woman . . . The first drunk insisted it could have been an artist since women have such aesthetic qualities . . . The 2nd drunk said, "I vote for an engineer . . . Only an engineer can create a woman so structurally perfect . . . The 3rd drunk was more pragmatic . . . "It must have been someone from our City Planning Commission . . . Who else would have put the playground adjacent to the waste disposal . . ." (Another **Ken Ozaki** joke)

A local guy goes to a doctor for a checkup . . . "Say Doc, I have a problem with my toes," he sez pointing to his slightly gnarled toes . . . "You don't suppose I had 'tolio' as a kid?" Physician corrects him, "No, no, that's polio, not tolio." "Doc, I also have bum knees . . . You think I may have neasles?" Physician: "No, you mean measles, not neasles . . . Now, drop your trousers so I can check your genitals . . . Oh, my ghosh! Don't tell me you had 'small cox' too!" exclaimed the dumbfounded physician . . . (As told by **Sharon Bintliff**, our woman marathon runner who did it in 4 hrs 3 min)

"Someone called you an owl . . ." "Whoo?"

"What were you doing under there?" "Underwear?"

Someone driving a Mercedes Benz ran into a trailer truck . . . Is that why the Mercedes bends? (As told by Charley Ching's son . . . From the mouths of babes)

A fellow new in town was looking for some action and went into this bar . . . As he ordered a drink, he noticed a good looking blonde drinking alone. He moseys over and offers to buy her a drink . . . The bartender warns, "Don't waste your money on her . . . She's a Lesbian . . ." "That's OK by me," he says and turning to the blonde, asks, "What part of Lesbia are you from?" (As told by our golfing dentist, **Ken Ozaki**)

The kindly grandfather was walking his 6-year-old grandson in the park when they encountered two dogs copulating . . . "Grandpa! What are they doing?" asks the grandson . . . "Well, the dog on top has hurt his front paws and the other dog is helping him walk," replies the quick witted grandpa . . . Muses the grandson, "Now, isn't that just like with humans . . . You try to help someone and you get screwed everytime . . ." (As told by golfer **Alan Luning** . . .)

Letters To The Editor

David A. Byrne, M.D.
727 West First Street
Bloomington, Indiana 47401

H. Yokoyama, MD
News Editor, Hawaii Medical Journal

Oct. 7, 1977

Dear Dr. Yokoyama,

Regarding the Letter to the Editor in the August Hawaii Medical Journal which was critical of the "dubious distinction of being the only one to print regularly off-colour jokes"; after yawning through several medical journals, it is always a pleasure to press through the Hawaii Medical Journal to the last column. It's obvious that it's difficult for Aloha Shirts to be "stuffed."

Yours sincerely,
David A. Byrne, MD

(Ed: We appreciate your support—Thanks and Aloha)



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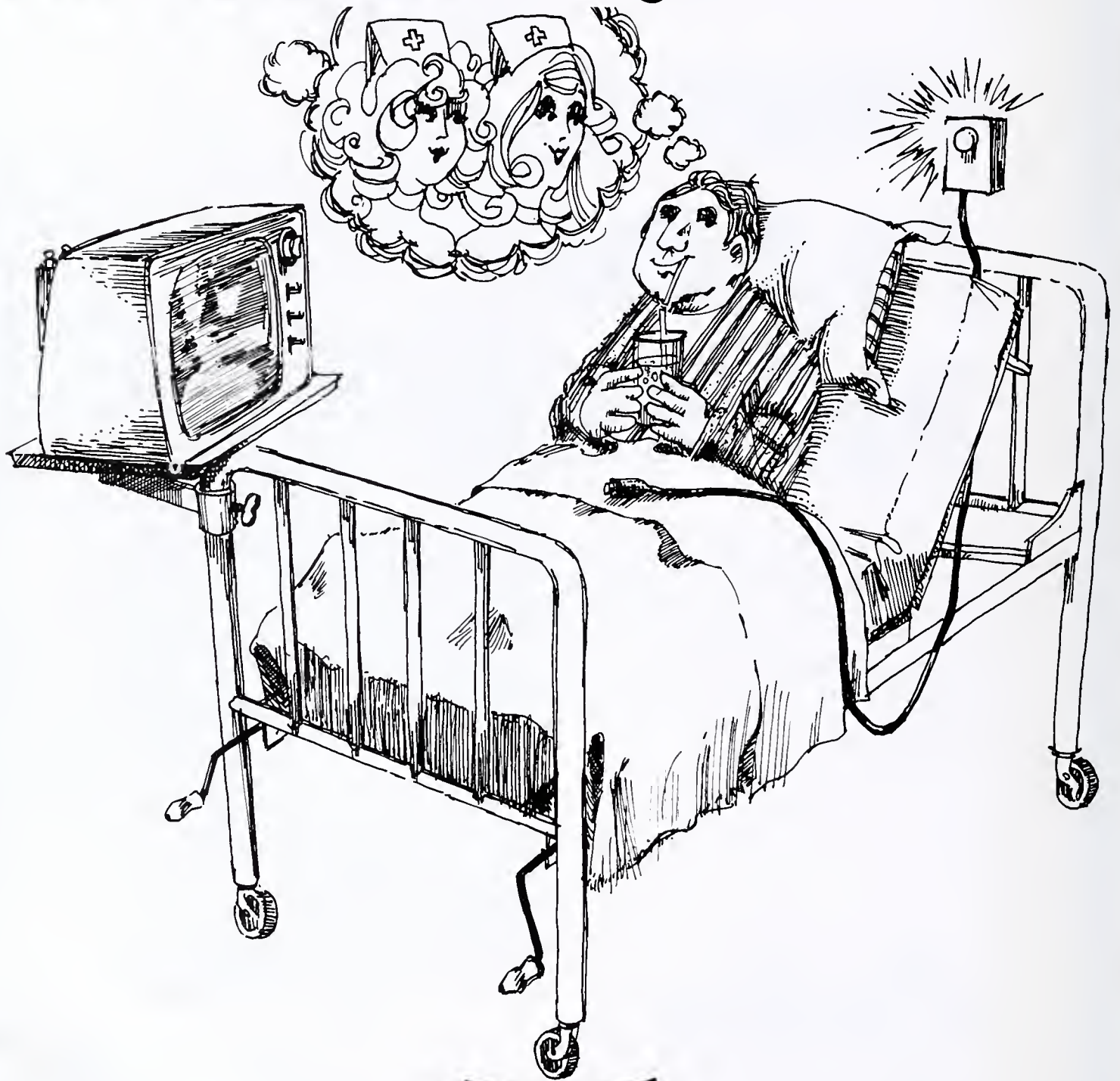
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